SOUTH CAROLINA STATE REGISTER DISCLAIMER

SOUTH CAROLINA STATE REGISTER

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This issue contains notices, proposed regulations, emergency regulations, final form regulations, and other documents filed in the Office of the Legislative Council, pursuant to Article 1, Chapter 23, Title 1, Code of Laws of South Carolina, 1976.

SOUTH CAROLINA STATE REGISTER

An official state publication, the *South Carolina State Register* is a temporary update to South Carolina's official compilation of agency regulations--the *South Carolina Code of Regulations*. Changes in regulations, whether by adoption, amendment, repeal or emergency action must be published in the *State Register* pursuant to the provisions of the Administrative Procedures Act. The *State Register* also publishes the Governor's Executive Orders, notices or public hearings and meetings, and other documents issued by state agencies considered to be in the public interest. All documents published in the *State Register* are drafted by state agencies and are published as submitted. Publication of any material in the *State Register* is the official notice of such information.

STYLE AND FORMAT

Documents are arranged within each issue of the *State Register* according to the type of document filed:

Notices are documents considered by the agency to have general public interest.
Notices of Drafting Regulations give interested persons the opportunity to comment during the initial drafting period before regulations are submitted as proposed.
Proposed Regulations are those regulations pending permanent adoption by an agency.
Pending Regulations Submitted to the General Assembly are regulations adopted by the agency pending approval by the General Assembly.
Final Regulations have been permanently adopted by the agency and approved by the General Assembly.
Emergency Regulations have been adopted on an emergency basis by the agency.
Executive Orders are actions issued and taken by the Governor.

2018 PUBLICATION SCHEDULE

Documents will be accepted for filing on any normal business day from 8:30 A.M. until 5:00 P.M. All documents must be submitted in the format prescribed in the *Standards Manual for Drafting and Filing Regulations*.

To be included for publication in the next issue of the *State Register*, documents will be accepted no later than 5:00 P.M. on any closing date. The modification or withdrawal of documents filed for publication must be made **by 5:00 P.M.** on the closing date for that issue.

	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
Submission Deadline	1/12	2/9	3/9	4/13	5/11	6/8	7/13	8/10	9/14	10/12	11/9	12/14
Publishing Date	1/26	2/23	3/23	4/27	5/25	6/22	7/27	8/24	9/28	10/26	11/23	12/28

REPRODUCING OFFICIAL DOCUMENTS

Documents appearing in the *State Register* are prepared and printed at public expense. Media services are encouraged to give wide publicity to documents printed in the *State Register*.

PUBLIC INSPECTION OF DOCUMENTS

Documents filed with the Office of the State Register are available for public inspection during normal office hours, 8:30 A.M. to 5:00 P.M., Monday through Friday. The Office of the State Register is in the Legislative Council, Fourth Floor, Rembert C. Dennis Building, 1000 Assembly Street, in Columbia. Telephone inquiries concerning material in the *State Register* or the *South Carolina Code of Regulations* may be made by calling (803) 212-4500.

ADOPTION, AMENDMENT AND REPEAL OF REGULATIONS

To adopt, amend or repeal a regulation, an agency must publish in the *State Register* a Notice of Drafting; a Notice of the Proposed Regulation that contains an estimate of the proposed action's economic impact; and, a notice that gives the public an opportunity to comment on the proposal. If requested by twenty-five persons, a public hearing must be held at least thirty days after the date of publication of the notice in the *State Register*.

After the date of hearing, the regulation must be submitted to the General Assembly for approval. The General Assembly has one hundred twenty days to consider the regulation. If no legislation is introduced to disapprove or enacted to approve before the expiration of the one-hundred-twenty-day review period, the regulation is approved on the one hundred twentieth day and is effective upon publication in the *State Register*.

EMERGENCY REGULATIONS

An emergency regulation may be promulgated by an agency if the agency finds imminent peril to public health, safety or welfare. Emergency regulations are effective upon filing for a ninety-day period. If the original filing began and expired during the legislative interim, the regulation can be renewed once.

REGULATIONS PROMULGATED TO COMPLY WITH FEDERAL LAW

Regulations promulgated to comply with federal law are exempt from General Assembly review. Following the notice of proposed regulation and hearing, regulations are submitted to the *State Register* and are effective upon publication.

EFFECTIVE DATE OF REGULATIONS

Final Regulations take effect on the date of publication in the *State Register* unless otherwise noted within the text of the regulation.
Emergency Regulations take effect upon filing with the Legislative Council and remain effective for ninety days. If the original ninety-day period begins and expires during legislative interim, the regulation may be refiled for one additional ninety-day period.

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Executive Order No. 2017-38

WHEREAS, I have been notified of the passing of Iris Rhodes Campbell; and

WHEREAS, Iris Rhodes Campbell, wife of the late Carroll A. Campbell, Jr., dutifully served the State of South Carolina as First Lady from 1987 to 1995 and was known as a beloved wife, mother, grandmother, public servant, friend, and zealous advocate for finding a cure to Alzheimer's disease; and

WHEREAS, section 10-1-161(E) of the South Carolina Code of Laws, as amended, authorizes the Governor to order that the flags atop the State Capitol Building be lowered to half-staff at a designated time or for a designated period of time upon the death of a person of extraordinary stature.

NOW, THEREFORE, by virtue of the authority vested in me as Governor of the State of South Carolina and pursuant to the Constitution and Laws of this State and the powers conferred upon me therein, I hereby Order that the flags atop the State Capitol Building be lowered to half-staff on Monday, November 27, 2017, in honor of Iris Rhodes Campbell and in recognition of her extraordinary service to the State of South Carolina. This Order is effective immediately.

GIVEN UNDER MY HAND AND THE GREAT SEAL OF THE STATE OF SOUTH CAROLINA, THIS 22nd DAY OF NOVEMBER, 2017.

HENRY MCMASTER
Governor

Executive Order No. 2017-39

WHEREAS, a vacancy will exist in the office of Coroner of Edgefield County due to the resignation of W. Thurmond Burnett, effective January 1, 2018; and

WHEREAS, in the event of a vacancy in the office of coroner, the undersigned is authorized to appoint a qualified replacement to serve in such office pursuant to sections 17-5-50 and 4-11-20 of the South Carolina Code of Laws, as amended; and

WHEREAS, David Thurmond Burnett, residing at 763 Columbia Road, Edgefield, South Carolina 29824, is a fit and proper person to serve as Coroner of Edgefield County.

NOW, THEREFORE, by virtue of the authority vested in me as Governor of the State of South Carolina and pursuant to the Constitution and Laws of this State and the powers conferred upon me therein, I hereby appoint David Thurmond Burnett to serve as Coroner of Edgefield County, effective January 1, 2018, until the next general election in accordance with section 17-5-50(A) of the South Carolina Code of Laws, as amended, and until his successor shall qualify as provided by law.

GIVEN UNDER MY HAND AND THE GREAT SEAL OF THE STATE OF SOUTH CAROLINA, THIS 29th DAY OF NOVEMBER, 2017.

HENRY MCMASTER
Governor

Executive Order No. 2017-40

WHEREAS, I have been notified of the passing of Ernest A. Finney, Jr.; and

WHEREAS, Ernest A. Finney, Jr. dutifully served the State of South Carolina as an educator, attorney, member of the South Carolina House of Representatives, circuit court judge, and associate justice and chief justice of the Supreme Court of South Carolina, and he was known as a remarkable man whose lifetime of service is an inspiration and whose unwavering belief in the Rule of Law provided hope and justice for all South Carolinians and added strength and confidence to the integrity of the Court; and

WHEREAS, section 10-1-161(E) of the South Carolina Code of Laws, as amended, authorizes the Governor to order that the flags atop the State Capitol Building be lowered to half-staff at a designated time or for a designated period of time upon the death of a person of extraordinary stature.

NOW, THEREFORE, by virtue of the authority vested in me as Governor of the State of South Carolina and pursuant to the Constitution and Laws of this State and the powers conferred upon me therein, I hereby Order that the flags atop the State Capitol Building be lowered to half-staff on Saturday, December 9, 2017, in honor of Chief Justice Finney and in recognition of his extraordinary service to the State of South Carolina. This Order is effective immediately.

GIVEN UNDER MY HAND AND THE GREAT SEAL OF THE STATE OF SOUTH CAROLINA, THIS 8th DAY OF DECEMBER, 2017.

HENRY MCMASTER
Governor

Executive Order No. 2017-41

WHEREAS, I have been notified of the passing of Corporal James Eric Chapman of the Johnston Police Department, who dutifully served as a law enforcement officer in this State and died in the line of duty; and

WHEREAS, Corporal Chapman dedicated his life to protecting and serving the citizens of the United States and the people of the State of South Carolina, both in the United States Marine Corps and with the Johnston Police Department; and

WHEREAS, section 1-3-470 of the South Carolina Code of Laws, as amended, authorizes the Governor, on the day of burial or other service for any firefighter or law enforcement officer in this State who died in the line of duty, to order that all flags on state buildings be lowered to half-staff in tribute to the deceased firefighter or law enforcement officer and to request that flags over the buildings of the political subdivisions of this State similarly be flown at half-staff for this purpose.

NOW, THEREFORE, by virtue of the authority vested in me as Governor of the State of South Carolina and pursuant to the Constitution and Laws of this State and the powers conferred upon me therein, I hereby Order that all flags on state buildings be lowered to half-staff from sunup to sundown on Wednesday, December 13, 2017, in tribute to Corporal Chapman, who died in the line of duty. I request that all flags over the buildings of the political subdivisions of this State similarly be flown at half-staff for this purpose. This Order is effective immediately.

GIVEN UNDER MY HAND AND THE GREAT SEAL OF THE STATE OF SOUTH CAROLINA, THIS 12th DAY OF DECEMBER, 2017.

HENRY MCMASTER
Governor

Executive Order No. 2017-42

Proclamation of a Statewide Public Health Emergency and Establishment of the Opioid Emergency Response Team

WHEREAS, opioids are a class of drugs that includes prescription pain relievers such as hydrocodone, oxycodone, codeine, and morphine, as well as illegal drugs such as heroin and analogs of the synthetic opioid analgesic fentanyl, such as carfentanyl; and

WHEREAS, the growing epidemic caused by the misuse and abuse of opioids and other similar controlled substances is one of the greatest challenges facing the State of South Carolina; and

WHEREAS, in May of 2013, the South Carolina State Inspector General highlighted the crisis by preparing a report on the need to implement a statewide strategy to combat prescription drug abuse, titled "South Carolina Lacks a Statewide Drug Abuse Strategy"; and

WHEREAS, on March 14, 2014, Executive Order No. 2014-22 established the Governor's Prescription Drug Abuse Prevention Council ("PDAP Council"), which was tasked with developing a comprehensive State Plan to combat prescription drug abuse; and

WHEREAS, the PDAP Council published the State Plan on October 1, 2014, which consisted of fifty-four (54) recommendations, and the PDAP Council completed its mission after ensuring implementation of most of the recommendations; and

WHEREAS, on May 9, 2017, the House Opioid Abuse Prevention Study Committee began meeting to discuss further State action to combat the opioid epidemic and is expected to publish a report with recommendations for the State in January of 2018; and

WHEREAS, as the Governor's Opioid Summit was held September 6 and 7, 2017, in collaboration with and sponsored by the Department of Alcohol and Other Drug Abuse Services ("DAODAS"), attracting nearly 600 attendees; and

WHEREAS, on October 26, 2017, President Donald J. Trump declared a public health emergency under the Public Health Services Act; and

WHEREAS, on November 1, 2017, President Trump's Commission on Combating Drug Addiction and the Opioid Crisis published a Final Report with fifty-six (56) recommendations to assist the President in combating the opioid crisis and drug addiction affecting the nation; and

WHEREAS, it is clear from the meetings and reports detailed above that South Carolina needs a comprehensive and continuous statewide strategy to address the opioid epidemic, as demonstrated by the increasing number of deaths related to opioid misuse, abuse, and overdose; and

WHEREAS, the following statistics further highlight the rapid increase in fatalities due to the opioid epidemic:

1. In 2016, 684 deaths occurred in South Carolina from overdose related to all types of prescription drugs as indicated by death certificates, which reflects an increase of 7% from 641 in 2015, and an increase of 12% from 572 in 2014.

2. The occurrence of deaths related to all opioids, including prescription drugs, is rising steadily, with a 21% increase from 2014 to 2016.

3. Fatal overdoses related to heroin increased by 67% from 2014 to 2015 and again increased by 14% from 2015 to 2016.

4. For the past three years, the number of opioid-related overdose deaths in South Carolina surpassed the number of homicides, with 2016 statistics reporting 616 opioid-related overdose deaths and 366 homicides.

5. In 2016, Horry, Charleston, Greenville, Richland, York, Spartanburg, Lexington, Pickens, Georgetown, and Berkeley Counties reported twenty-five (25) or more fatal opioid overdose occurrences.

6. Since 2015, the South Carolina Law Enforcement Division's ("SLED") forensic laboratory has seen an over 650 percent increase in the number of drug cases in South Carolina involving fentanyl-related compounds.

WHEREAS, the rise in deaths associated with the opioid epidemic continues to increase, causing a public health threat; and

WHEREAS, a state public health emergency exists when a qualifying health condition "poses a substantial risk of a significant number of human fatalities" pursuant to section 44-4-130(P), (R) of the South Carolina Code of Laws; and

WHEREAS, the increased prevalence of opioid use disorder and the increasing number of opioid-related deaths give rise to a public health emergency; and

WHEREAS, the opioid epidemic is a serious threat to the safety, security, and economic well-being of the State; and

WHEREAS, law enforcement must coordinate a concerted effort to stop the trafficking of prescription drugs and unlawful opioids; and

WHEREAS, coordination among state agencies, private entities, and law enforcement, and the ability to share data, capabilities, and processes is necessary to effectively combat the opioid epidemic.

NOW, THEREFORE, by virtue of the authority vested in me as Governor of the State of South Carolina and pursuant to the Constitution and Laws of this State and the powers conferred upon me therein, I hereby proclaim a statewide public health emergency exists in South Carolina relating to opioid misuse and abuse, opioid use disorder, and opioid-related deaths pursuant to section 1-3-420 of the South Carolina Code of Laws. The statewide public health emergency shall remain in place until modified, amended, or revoked by subsequent Executive Order. Emergency health powers triggered by a statewide public health emergency shall be activated and invoked only by additional Executive Orders identifying any such emergency health powers to be utilized.

Additionally, pursuant to section 1-3-440 of the South Carolina Code of Laws, I hereby authorize any and all law enforcement officers of the State or its subdivisions to act as necessary and consistent with the foregoing to maintain good order during this statewide public health emergency. Also, pursuant to section 1-3-480 of the South Carolina Code of Laws, I hereby authorize the Adjutant General to enter into mutual assistance and support agreements with law enforcement agencies as needed to support drug interdiction, counterdrug activities, and demand reduction activities.

Further, recognizing the need for urgent action to effectively coordinate federal, state, and local resources to address this health crisis, I hereby establish the Opioid Emergency Response Team ("Team"), as outlined below, to ensure coordination and collaboration among government agencies, private entities and associations, and state and local law enforcement authorities in the fight against the opioid crisis:

A. Co-Chairs and Coordination of the Opioid Emergency Response Team:

The Team shall be co-chaired by the Director of DAODAS and the Chief of SLED. Team meetings shall be hosted at the South Carolina Emergency Management Division ("SCEMD") due to its experience with and comprehensive approach to emergency preparedness, response, recovery, and mitigation. SCEMD is active in the management of public health crises and has contacts with state and local officials that will benefit the Team in coordinating this statewide effort.

B. Members of the Opioid Emergency Response Team:

The Team will consist of the following members:

1. One representative from each of the following State agencies or entities, as designated by the director or chief of the same: DADOAS; SLED; SCEMD; South Carolina Department of Health and Human Services; South Carolina Department of Labor, Licensing and Regulation; South Carolina Department of Health and Environmental Control; the South Carolina Commission on Prosecution Coordination; the Department of Public Safety; and the Medical University of South Carolina;

2. The Attorney General of South Carolina or his designee;

3. The Adjutant General of South Carolina or his designee;

4. Representation from the following private entities and associations upon invitation by the Co-Chairs: local law enforcement; third party health plans; South Carolina Coroner's Association; South Carolina Chapter of American Association for the Treatment of Opioid Dependence ("SC AATOD"); South Carolina Behavioral Health Services Association; American College of Emergency Physicians ("ACEP"); and a citizen representative in recovery;

5. Representation from federal agencies, such as the Drug Enforcement Agency ("DEA") and the Postal Inspector, upon invitation by the Chief of SLED, to coordinate federal resources and assist in the interdiction of drugs; and

6. Other representatives may be invited by the Governor or Co-Chairs to serve on the Team or attend various Team meetings as needed.

C. Opioid Emergency Response Team Purpose:

The Team shall hold its first meeting on December 19, 2017, at 2:30 P.M. The Team shall thereafter meet at least monthly for the first six (6) months and shall thereafter meet at the call of the Governor or the Co-Chairs as needed to ensure continued collaboration. The Team shall coordinate best practices and address action items related to the opioid crisis, including but not limited to the following:

1. Review resources to determine needed action items and strategies:

a. Recommendations from the President's Commission on Combating Drug Addiction and the Opioid Crisis;

b. Recommendations from the South Carolina House Opioid Abuse Prevention Study Committee;

c. Recommendations set forth in the South Carolina State Plan created and implemented by the Prescription Drug Abuse Council;

d. Strategies and actions in place in South Carolina, other states, and recommended by the National Governors Association; and

e. Other information as determined by the Team.

2. Draft an Opioid Abuse State Plan by June of 2018 with a list of action items. The Opioid Abuse State Plan should be continually revised to move the State forward in combatting the opioid crisis. Action items may recommend agency policies, regulations, and legislation.

3. Coordinate state agencies and private stakeholders to implement the Opioid Abuse State Plan and limit duplication of services.

4. Identify federal and state funding streams that can be directed to combat opioid abuse, misuse, and overdose.

5. Encourage data sharing between law enforcement authorities, state agencies, and private entities to combat drug use and the interdiction of drug sources. Inclusion of federal law enforcement authorities will be utilized to stop illegal opioids from entering South Carolina.

6. Share information on the presence of highly lethal synthetic drugs in geographic areas of the State and communicate information through social media and other resources to prevent further deaths.

7. Recommend and implement training for state and local law enforcement authorities regarding referrals of opioid abuse victims to public and mental health agencies.

8. Educate state and local law enforcement and local health officials regarding the benefits and administration of naloxone in preventing both prescription and illicit opioid deaths.

9. Recommend ways to strengthen the current Prescription Drug Monitoring Program ("PDMP"), known as SCRIPTS.

10. Review options to incorporate treatment for individuals prior to, during, after, or in lieu of incarceration, to include the expansion of drug courts.

11. Take all other and further actions as deemed necessary by the Team.

This Order is effective immediately.

GIVEN UNDER MY HAND AND THE GREAT SEAL OF THE STATE OF SOUTH CAROLINA, THIS 18th DAY OF DECEMBER, 2017.

HENRY MCMASTER
Governor

Executive Order No. 2017-43

WHEREAS, South Carolina recognizes the growing epidemic caused by the misuse and abuse of prescription opioids, including prescription pain relievers such as hydrocodone, oxycodone, codeine, and morphine; and

WHEREAS, opioids are often used as conventional treatment for pain when there are other, less addictive options that can be used to treat pain-related symptoms and conditions;

WHEREAS, practical limitations on opioid prescribing behaviors for acute and post-operative pain management may prevent future drug dependency and addiction; and

WHEREAS, the State should mitigate opportunities for prescription diversion that enable substance use disorders involving both prescription drugs and illegal drugs; and

WHEREAS, a 2013 study by the National Institute on Drug Abuse found that 80 percent of heroin users reported using prescription opioids before heroin; and

WHEREAS, statistics from the Centers for Disease Control and Prevention show that from 1999 to 2014, sales of prescription opioids in the United States almost quadrupled without changes in pain reported; and

WHEREAS, the Centers for Disease Control and Prevention's "Annual Surveillance Report of Drug-related Risks and Outcomes–United States, 2017" publication states that nationally almost 20% of individuals receive one or more opioid prescriptions per year; and

WHEREAS, the State should be a leader on the management of pain medications and encourage health providers to adopt a common policy on opioid prescribing limitations; and

WHEREAS, current national data supports limiting opioid prescription length and dosage; and

WHEREAS, physicians should prescribe opioids in the lowest dose and for the shortest length of time necessary to address acute and post-operative pain issues; and

WHEREAS, South Carolina has recognized this need and in August of 2017, the South Carolina State Boards of Dentistry, Medical Examiners, Nursing, and Pharmacy issued "Joint Revised Pain Management Guidelines" indicating that in many acute and post-operative pain management cases, a prescription of three (3) days or less is sufficient, and a seven (7) day prescription is rarely needed; and

WHEREAS, data released by the Centers for Disease Control and Prevention shows that the probability of long-term opioid use increases in the first few days of therapy, with the sharpest increase in long-term opioid use observed after the fifth and thirty-first days of opioid therapy prescribed; and

WHEREAS, the State should curtail the use of public resources that may enable prescription diversion.

NOW, THEREFORE, by virtue of the authority vested in me as Governor of the State of South Carolina and pursuant to the Constitution and Laws of this State and the powers conferred upon me therein, I hereby direct the South Carolina Department of Health and Human Services ("DHHS") to develop and publish a two-part policy applicable to all healthcare providers DHHS reimburses directly or through a third-party for services that include prescribing, dispensing, or administering controlled substances. The two-part policy will apply to all programs administered by DHHS, to include Medicaid reimbursement.

(1) DHHS shall develop and publish a policy with a 5-day prescription limitation on initial opioid prescriptions for acute and post-operative pain management. The policy shall provide for exceptions to this limitation when clinically indicated for situations such as chronic pain, cancer pain, and palliative care.

(2) DHHS shall develop and publish a policy regarding opioid dosing thresholds and recommend best practices that require legislative or regulatory solutions to the Opioid Emergency Response Team.

DHHS shall develop and publish said two-part policy on or before March 1, 2018, and said policies shall be implemented as soon as reasonable after publication.

Nothing in this Executive Order is intended to invade the practitioner–patient relationship or intrude into the prescriber's area of expertise. The purpose of the Executive Order is to limit the scope of acute and post-operative situations to prevent the initiation of dependency and addiction.

This Order is effective immediately.

GIVEN UNDER MY HAND AND THE GREAT SEAL OF THE STATE OF SOUTH CAROLINA, THIS 18th DAY OF DECEMBER, 2017.

HENRY MCMASTER
Governor

Executive Order No. 2017-44

WHEREAS, a vacancy will exist in the office of the Treasurer of Orangeburg County due to the resignation of J. Steve Summers, effective January 31, 2018; and

WHEREAS, in the event of a vacancy in the office of a county treasurer, the undersigned is authorized to appoint a suitable person, who shall be an elector of the county, to serve as county treasurer pursuant to sections 1-3-220(2), 4-11-20(1), and 12-45-20 of the South Carolina Code of Laws, as amended; and

WHEREAS, E. Madison Stokes, residing at 710 Shuler Belt Road, Holly Hill, South Carolina 29059, is a fit and proper person to serve as the Treasurer of Orangeburg County.

NOW, THEREFORE, by virtue of the authority vested in me as Governor of the State of South Carolina and pursuant to the Constitution and Laws of this State and the powers conferred upon me therein, I hereby appoint E. Madison Stokes to serve as Treasurer of Orangeburg County, effective January 31, 2018, until the next general election and until his successor shall qualify as provided by law.

GIVEN UNDER MY HAND AND THE GREAT SEAL OF THE STATE OF SOUTH CAROLINA, THIS 27th DAY OF DECEMBER, 2017.

HENRY MCMASTER

DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

NOTICE OF GENERAL PUBLIC INTEREST

January 26, 2018

In accordance with Section 44-7-200(D), Code of Laws of South Carolina, the public is hereby notified that a Certificate of Need application has been accepted for filing and publication January 26, 2018 for the following project(s). After the application is deemed complete, affected persons will be notified that the review cycle has begun. For further information, please contact Nic Gerrald, Certificate of Need Program, 2600 Bull Street, Columbia, SC 29201 at (803) 545-3495.

Affecting Anderson County

Well Care Home Health of the Upstate, Inc.
Establishment of a Home Health Agency in Anderson County at a total project cost of $29,000.

Affecting Beaufort County

Broad River Oncology, LLC d/b/a Broad River Radiation Therapy Center
Development of a radiation therapy cancer center with a linear accelerator at a total project cost of $12,014,596.

Affecting Berkeley County

Palmetto Lowcountry Behavioral Health
The transfer of 44 psychiatric beds and 16 substance abuse beds and the addition of 48 psychiatric beds for a total of 108 beds in a newly constructed facility at a total project cost of $35,529,725.

Medical University Hospital Authority d/b/a MUHA Community Hospital
Construction of a 128-bed general acute hospital in Berkeley County at a total project cost of $325,000,000.

Affecting Greenville County

Well Care Home Health of the Upstate, Inc.
Establishment of a Home Health Agency in Greenville County at a total project cost of $36,500.

Upstate Affiliate Organization d/b/a GHS Greenville Memorial Hospital
Conversion of 24 level II NICU beds to level III for a total of 36 level III NICU beds at a total project cost of $6,530.

Affecting Lexington County

Lexington Treatment Specialists, LLC
Establishment of an outpatient substance abuse facility at a total project cost of $114,400.

Affecting Spartanburg County

Well Care Home Health of the Upstate, Inc.
Establishment of a Home Health Agency in Spartanburg County at a total project cost of $29,000.

In accordance with Section 44-7-210(A), Code of Laws of South Carolina, and S.C. DHEC Regulation 61-15, the public and affected persons are hereby notified that for the following projects, applications have been deemed complete, and the review cycle has begun. A proposed decision will be made as early as 30 days, but no later

than 120 days, from January 26, 2018. "Affected persons" have 30 days from the above date to submit requests for a public hearing to Nic Gerrald, Certificate of Need Program, 2600 Bull Street, Columbia, S.C. 29201. If a public hearing is timely requested, the Department's decision will be made after the public hearing, but no later than 150 days from the above date. For further information call (803) 545-3495.

Affecting Anderson County

Well Care Home Health of the Upstate, Inc.
Establishment of a Home Health Agency in Anderson County at a total project cost of $29,000.

Affecting Greenville County

Well Care Home Health of the Upstate, Inc.
Establishment of a Home Health Agency in Greenville County at a total project cost of $36,500.

Affecting Lexington County

Lexington Treatment Specialists, LLC
Establishment of an outpatient substance abuse facility at a total project cost of $114,400.

Affecting Spartanburg County

Well Care Home Health of the Upstate, Inc.
Establishment of a Home Health Agency in Spartanburg County at a total project cost of $29,000.

DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

NOTICE OF GENERAL PUBLIC INTEREST

DHEC-Bureau of Land and Waste Management, File # 58513
NorthPointe OS Site

January 26, 2018

NOTICE OF VOLUNTARY CLEANUP CONTRACT, CONTRIBUTION PROTECTION, AND COMMENT PERIOD

PLEASE TAKE NOTICE that the South Carolina Department of Health and Environmental Control (the Department) intends to enter into a Voluntary Cleanup Contract (VCC) with NorthPointe OS, LLC and Greenville-NorthPointe Associates, LLC (the Respondents). The VCC provides that the Respondents, with DHEC's oversight, will fund and perform future response actions at the Property located in Greenville County, at 405 East Stone Avenue, Greenville, South Carolina (Site).

Future response actions addressed in the VCC include, but may not be limited to, the Respondents funding and performing a Remedial Investigation to determine the source, nature, and extent of release of hazardous substances, pollutants, or contaminants and, if necessary, a Feasibility Study to evaluate alternatives to clean-up the Site. Further, the Respondents will reimburse the Department's future costs of overseeing the work performed by the Respondents and other Department response costs pursuant to the VCC.

The VCC is subject to a thirty-day public comment period consistent with the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA), 42 U.S.C. Section 9613, and the South Carolina Hazardous Waste Management Act (HWMA), S.C. Code Ann. Section 44-56-200 (as amended). Notice of

14 NOTICES

Contribution Protection and Comment Period will be provided to known potentially responsible parties. The VCC is available:

(1) On-line at http://www.scdhec.gov/PublicNotices; or
(2) By contacting David Wilkie at 803-898-0882 or wilkietd@dhec.sc.gov.

Any comments to the proposed VCC must be submitted in writing, postmarked no later February 26, 2018 and addressed to: David Wilkie, DHEC-BLWM-SARR, 2600 Bull Street, Columbia, SC 29201.

Upon the successful completion of the VCC, the Respondents will receive a covenant not to sue for the work done in completing the response actions specifically covered in the VCC and completed in accordance with the approved work plans and reports. Upon execution of the VCC, the Respondents shall be deemed to have resolved its liability to the State in an administrative settlement for purposes of, and to the extent authorized under CERCLA, 42 U.S.C. Sections 9613(f)(2) and 9613(f)(3)(B), and under HWMA, S.C. Code Ann. Section 44-56-200, for the matters addressed in the VCC. Further, to the extent authorized under 42 U.S.C. Section 9613(f)(3)(B), S.C. Code Ann. Section 44-56-200, the Respondents may seek contribution from any person who is not a party to this administrative settlement.

DEPARTMENT OF CONSUMER AFFAIRS

CHAPTER 28

Statutory Authority: 1976 Code Sections 37-6-104, 37-6-402, 37-6-403, and 37-6-506

Notice of Drafting:

The South Carolina Department of Consumer Affairs proposes to promulgate R.28-55 addressing the revocable assignment of wages. Interested persons should submit their views in writing to Kelly Rainsford, Deputy for Regulatory Enforcement, South Carolina Department of Consumer Affairs, P.O. Box 5757, Columbia, South Carolina 29250-5757. To be considered, comments must be received no later than February 28, 2018, the close of the drafting comment period.

Synopsis:

Sections 37-2-410 (last amended in 1974), 37-2-710 (passed in 1985) and 37-3-403 (last amended 1974) permit a consumer to authorize the revocable assignment of wages pertaining to a debt arising from a credit sale, consumer lease, loan or rental-purchase transaction. The South Carolina Department of Consumer Affairs proposes to provide a framework for the provision of a revocable assignment of wages, including format and disclosure requirements.

This regulation will require legislative review.

Document No. 4808
CLEMSON UNIVERSITY
STATE CROP PEST COMMISSION
CHAPTER 27
Statutory Authority: 1976 Code Section 46-9-40

27-160. Plant Nursery Regulations.

Preamble:

The State Crop Pest Commission proposes to provide clarifying language regarding the regulation of nursery plant shipments and fees for nursery dealers in South Carolina in response to recent statutory amendments made to the enabling legislation in the 2017 legislative session.

Section-by-Section Discussion

27-160. Plant Nursery Regulation
Replace and add new text with definitions to be used throughout this section.

27-161. Nursery Certification Process
Replace and add new text to reorganize this section and clarify the Nursery Certification process.

27-162. Nursery Dealer Certification Process
Replace and add new text to reorganize section and clarify the Nursery Dealer Certification process.

27-163. Nursery Stock Shipment
Replace and add new text to reorganize section and allow for multiple options for acquiring shipping tags.

27-164. Penalties
Replace and add new text indicating the ramifications for failure to follow the terms and provisions of these regulations.

A Notice of Drafting regarding the subject matter of the proposed regulation was published in the *State Register* on November 24, 2017.

Notice of Public Hearing and Opportunity for Public Comment:

All written comments and requests for a public hearing should be sent to Dr. Stephen E. Cole, Director, Regulatory Services, Clemson University, 511 Westinghouse Road, Pendleton, SC 29670. A hearing will be held at 511 Westinghouse Road, Pendleton, SC starting at 10:00 am on February 28, 2018, unless no requests are made by February 26, 2018, at which time the hearing on February 28, 2018 will be cancelled.

Preliminary Fiscal Impact Statement:

There will be no increased cost to the State or its political subdivisions.

Statement of Need and Reasonableness:

DESCRIPTION OF REGULATION:

Purpose: The proposed regulations will clarify and align the current Plant Nursery Regulations with the recently updated enabling legislation.

Legal Authority: S.C. Code Ann. Section 46-9-40.

Plan for Implementation: The restructuring of Plant Nursery Regulations affecting all plant nurseries and nursery dealers in SC will account for recent statute changes and clarify the intent and historical enforcement of the previous regulations and will be initiated immediately. Shipping tag acquisition options will be made available to all through the expansion of this regulation.

DETERMINATION OF NEED AND REASONABLENESS OF THE PROPOSED REGULATION BASED ON ALL FACTORS HEREIN AND EXPECTED BENEFITS:

The proposed regulation changes will clarify the existing Plant Nursery Regulations for better user understanding and more efficient application of the regulations following changes that were recently made to the enabling legislation in the 2017 legislative session.

DETERMINATION OF COSTS AND BENEFITS:

These proposed clarifications to the current regulations will not likely increase the costs or fees associated with the current regulations, but they will provide the benefit of greater clarification when applying for the various certifications and may in some instances reduce industry costs.

UNCERTAINTIES OF ESTIMATES:

None.

EFFECT ON ENVIRONMENT AND PUBLIC HEALTH:

None.

DETRIMENTAL EFFECT ON THE ENVIRONMENT AND PUBLIC HEALTH IF THE REGULATION IS NOT IMPLEMENTED:

None.

Statement of Rationale:

Clarification to certain terms and their applications are needed in order to effectively interpret recent changes to the enabling statute, which occurred during the 2017 Legislative session. These proposed updates should provide clarification and allow greater efficiency, by all affected parties subject to these plant nursery regulations.

Text:

The full text of this regulation is available on the South Carolina General Assembly Home Page: **http://www.scstatehouse.gov/regnsrch.php.** Full text may also be obtained from the promulgating agency.

Document No. 4809
DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
CHAPTER 61
Statutory Authority: 1976 Code Section 44-7-260

Preamble:

The Department of Health and Environmental Control ("Department") proposes a new regulation to establish licensure and regulatory requirements for Crisis Stabilization Unit ("CSU") Facilities. These facilities provide a short-term residential program offering psychiatric stabilization services and brief, intensive crisis services to individuals eighteen (18) years of age or older, twenty-four (24) hours a day, seven (7) days a week. Legislative review is required.

The Department had a Notice of Drafting published in the May 26, 2017, *State Register*.

Section-by-Section Discussion of Proposed New Regulation

Regulation 61-125. Standards for Licensing Crisis Stabilization Unit Facilities.

Added the statutory authority for the regulation under the Title

TABLE OF CONTENTS

The table of contents was added.

Section 100. DEFINITIONS AND LICENSURE
Section 100 title was added for clarity and consistency.

Section 101. Definitions.
The definitions of 101.A Abuse, 101.B Administrator, 101.C Adult, 101.D Annual, 101.E Assessment, 101.F Authorized Healthcare Provider, 101.G Blood Assay for *Mycobacterium tuberculosis*, 101.H Client, 101.I Contact Investigation, 101.J Controlled Substance, 101.K Consultation, 101.L Crisis Stabilization Unit Facility, 101.M Department, 101.N Designee, 101.O Direct Care Staff, 101.P Discharge, 101.Q Dispensing Medication, 101.R Elopement, 101.S Exploitation, 101.T Facility, 101.U Health Assessment, 101.V Incident, 101.W Individual Treatment Plan, 101.X Inspection, 101.Y Investigation, 101.Z Latent TB Infection, 101.AA Legend Drug, 101.BB License, 101.CC Licensed Nurse, 101.DD Licensee, 101.EE Medication, 101.FF Neglect, 101.GG Non-legend Drug, 101.HH Physical Examination, 101.II Physician, 101.JJ Physician Assistant, 101.KK Quality Improvement Program, 101.LL Quarterly, 101.MM Restraint, 101.NN Revocation of License, 101.OO Screening, 101.PP Self-Administration, 101.QQ Staff Member, 101.RR Suspension of License, 101.SS Tuberculosis Risk Assessment, and 101.TT Volunteer were added.

Section 102. Licensure.
Section 102.A was added to require facilities to obtain a license before operating. Section 102.B was added to require compliance with applicable local, state, and federal laws, codes, and regulations. Section 102.C was added to delineate the licensed bed capacity requirements. Section 102.D was added to delineate the terms of licensure. Section 102.E prohibits facilities from utilizing the same name as another licensed facility. Section 102.F delineates the requirements for the license application. Section 102.G lists the documentation required for licensure. Section 102.H delineates the licensing fees. Section 102.I delineates fees for late renewals. Section 102.J delineates the process for license renewal. Section 102.K outlines the requirements for a change of license. Section 102.L delineates the requirements when there is a change of licensee. Section 102.M allows the Department to make exceptions where the Department determines the health, safety, and well-being of clients are not compromised, and provided the standard is not specifically required by statute.

Section 200. ENFORCEMENT OF REGULATIONS
Section 200 title was added for clarity and consistency.

Section 201. General.
Section 201 delineates the methods by which the Department may enforce this regulation.

Section 202. Inspections and Investigations.
Section 202 requires that inspections by the Department be conducted prior to initial licensing of a facility. Section 202 further states that the Department may charge a fee for plan inspections, construction inspections, and licensing inspections, in accordance with S.C. Code Section 44-7-260, and lists the applicable fees.

Section 203. Consultations.
Section 203 allows for consultations by the Department as requested by the facility or as deemed appropriate by the Department.

Section 300. ENFORCEMENT ACTIONS
Section 300 title was added for clarity and consistency.

Section 301. General.
Section 301 states that the Department may impose a monetary penalty, or deny, suspend, or revoke licensure for statutory or regulatory violations.

Section 302. Violation Classifications.
Section 302 delineates the classes of violations and outlines the monetary penalty schedule for violations.

Section 400. POLICIES AND PROCEDURES
Section 400 requires facilities to have written policies and procedures addressing the manner in which the requirements of this regulation shall be met. Section 400 further delineates the requirements of facility policies and procedures.

Section 500. STAFF AND TRAINING
Section 500 title was added for clarity and consistency.

Section 501. General.
Section 501 requires criminal background checks for staff members and volunteers, delineates required qualifications for staff members, and requires verification of licenses, credentials, experience, and competence of staff members.

Section 502. Administrator.
Section 502 delineates the requirements for the facility administrator.

Section 503. Staff.
Section 503 delineates the minimum required staffing levels for facilities and requires at least one (1) registered nurse on duty and present in the facility twenty-four (24) hours per day, seven (7) days per week.

Section 504. Inservice Training.
Section 504 delineates the required inservice training for staff.

Section 505. Job Orientation.
Section 505 requires that all new staff members and volunteers have documented orientation to the organization and environment of the facility and specific duties and responsibilities.

Section 506. Health Status.
Section 506 requires that all staff members have a health assessment within twelve (12) months prior to initial client contact.

Section 600. REPORTING
Section 600 title was added for clarity and consistency.

Section 601. Incidents.
Section 601 delineates the requirements for reporting incidents occurring in the facility or on facility grounds, as well as requirements for other reportable conditions.

Section 602. Closure and Zero Census.
Section 602 delineates the reporting requirements for facility closure and requires facilities to notify the Department when there have been no clients in the facility for a period of ninety (90) days or more.

Section 700. CLIENT RECORDS
Section 700 title was added for clarity and consistency.

Section 701. Content.
Section 701 delineates the required documentation for client records.

Section 702. Screening.
Section 702 requires facilities to have written protocols for screening individuals presenting for evaluation.

Section 703. Assessments.
Section 703 requires a nursing assessment for all persons admitted to the facility within twenty-four (24) hours of admission and requires the assessment to be performed by a registered nurse. Section 703 further requires an emotional and behavioral assessment for all persons admitted to the facility within twenty-four (24) hours of admission.

Section 704. Individual Treatment Plan.
Section 704 requires that the treatment plan be completed within twenty-four (24) hours of admission and delineates the requirements thereof.

Section 705. Record Maintenance.
Section 705 delineates the requirements for maintaining client records and requires the facility to maintain client records for at least six (6) years following discharge of the client.

Section 800. ADMISSION AND RETENTION
Section 800 delineates the requirements for client admission and specifies clients which are not appropriate for admission.

Section 900. CLIENT CARE AND SERVICES
Section 900 title was added for clarity and consistency.

Section 901. General.
Section 901 requires written informed consent between the client and the facility and delineates the requirements of the written informed consent.

Section 902. Transportation.
Section 902 requires the facility to secure or provide transportation for clients when a physician's services are needed.

Section 903. Safety Precautions and Restraints.
Section 903 requires written policies and procedures for using seclusion or any form of restraint. Section 903 further delineates the requirements for utilizing seclusion and restraint.

Section 904. Discharge and Transfer.
Section 904 requires discharge planning to begin at the time of admission. Section 904 further delineates the requirements of the discharge summary.

Section 1000. RIGHTS AND ASSURANCES
Section 1000 requires the facility to comply with all current federal, state, and local laws and regulations concerning client care, client rights and protections, and privacy and disclosure requirements.

Section 1100. CLIENT PHYSICAL EXAMINATION AND TB SCREENING
Section 1100 requires that all persons admitted to the facility be provided a physical examination within twenty-four (24) hours of admission. Section 1100 further requires that the physical examination be performed only by a physician or other authorized healthcare provider.

Section 1200. MEDICATION MANAGEMENT
Section 1200 title was added for clarity and consistency.

Section 1201. General.
Section 1201 requires that all medications be properly managed in accordance with federal, state, and local laws and regulations.

Section 1202. Medication and Treatment Orders.
Section 1202 delineates the requirements for medication and treatment orders.

Section 1203. Administering Medication and/or Treatments.
Section 1203 requires that medications be administered in accordance with orders from the attending physician or other individual legally authorized to prescribe medications and delineates the requirements for self-administration of medication.

Section 1204. Medication Containers.
Section 1204 delineates the requirements for labeling medication containers.

Section 1205. Medication Storage.
Section 1206 delineates the requirements for storing medications within the facility.

Section 1206. Disposition of Medications.
Section 1209 delineates the requirements for client medications upon discharge from the facility.

Section 1300. MEAL SERVICE
Section 1300 title was added for clarity and consistency.

Section 1301. General.
Section 1301 requires that facilities preparing food on-site comply with Regulation 61-25, Retail Food Establishments. Section 1301 further requires that if a facility utilizes an outside source for meals, the outside source shall be graded by the Department, pursuant to R.61-25.

Section 1302. Meals and Special Diets.
Section 1302 requires the facility to offer a minimum of three (3) nutritionally-adequate meals in each twenty-four (24) hours period.

Section 1303. Diets.
Section 1303 delineates requirements when a facility accepts clients in need of medical-prescribed special diets.

Section 1304. Menus.
Section 1304 requires menus to be readily available and posted in one (1) or more conspicuous places in a public area.

Section 1305. Ice and Drinking Water.
Section 1305 requires the facility to utilize ice from a water system in compliance with Regulation 61-58, State Primary Drinking Water Regulations.

Section 1400. EMERGENCY PROCEDURES AND DISASTER PREPAREDNESS
Section 1400 title was added for clarity and consistency.

Section 1401. Disaster Preparedness.
Section 1401 requires facilities to develop a written plan to be activated in the event of a disaster and/or emergency evacuation and delineates the requirements thereof.

Section 1402. Emergency Call Numbers.
Section 1402 requires the facility to post emergency call data in a conspicuous place and shall include phone numbers for fire and police departments, ambulance service, and the poison control center.

Section 1403. Continuity of Essential Services.
Section 1403 requires the facility to have a written plan to be implemented to ensure the continuation of essential client support services during times of emergency or disaster.

Section 1500. FIRE PREVENTION
Section 1500 title was added for clarity and consistency.

Section 1501. Arrangements for Fire Department Response and Protection.
Section 1501 requires the facility to coordinate with local fire departments to ensure response during times of need.

Section 1502. Tests and Inspections.
Section 1502 requires that fire protection and suppression systems be maintained and tested in accordance with applicable building codes.

Section 1503. Fire Response Training.
Section 1503 delineates the minimum requirements for fire response training for facility staff.

Section 1504. Fire Drills.
Section 1504 requires the facility to conduct an unannounced fire drill at least quarterly for all shifts. Section 1504 further requires that all clients participate in fire drills.

Section 1600. MAINTENANCE
Section 1600 requires the facility to keep all equipment and building components in good repair and operating condition.

Section 1700. INFECTION CONTROL AND ENVIRONMENT
Section 1700 title was added for clarity and consistency.

Section 1701. Staff Practices.
Section 1701 requires the facility to promote practices that shall prevent the spread of infectious, contagious, or communicable diseases and provide for the proper disposal of toxic and hazardous substances.

Section 1702. Tuberculosis Risk Assessment and Screening.
Section 1702 requires the facility to conduct an annual tuberculosis risk assessment in accordance with CDC guidelines and delineates the requirements thereof.

Section 1703. Housekeeping.
Section 1703 requires the facility to keep its grounds clean and free of vermin and offensive odors and delineates the requirements for interior and exterior housekeeping.

Section 1704. Infectious Waste.
Section 1704 requires that all infectious waste be disposed of in a manner compliant with OSHA standards and Regulation 61-105, Infectious Waste Management Regulations.

Section 1705. Clean and Soiled Linen and Clothing.
Section 1705 requires the facility to maintain a supply of clean, sanitary linen and clothing at all times. Section 1705 further delineates the requirements for soiled linen and clothing.

Section 1800. QUALITY IMPROVEMENT PROGRAM
Section 1800 requires the facility to implement a written quality improvement program and delineates the requirements thereof.

Section 1900. DESIGN AND CONSTRUCTION
Section 1900 title was added for clarity and consistency.

Section 1901. General.
Section 1901 requires that there be at least two hundred (200) square feet per licensed bed in facilities with ten (10) beds or less, and at least an additional one hundred (100) square feet per licensed bed in facilities with more than ten (10) beds.

Section 1902. Codes and Standards.
Section 1902 requires the facility to comply with codes officially adopted by the South Carolina Building Codes Council and the South Carolina State Fire Marshal.

Section 1903. Submission of Plans.
Section 1903 delineates actions taken by the facility which necessitate submission of plans to the Department.

Section 1904. Inspections.
Section 1904 requires that all projects obtain all required permits from the locality having jurisdiction.

Section 2000. FIRE PROTECTION, PREVENTION, AND LIFE SAFETY
Section 2000 requires facilities with six (6) or more licensed beds to have a partial, manual, automatic, supervised fire alarm system.

Section 2100. GENERAL CONSTRUCTION REQUIREMENTS
Section 2100 title was added for clarity and consistency.

Section 2101. Floor Finishes.
Section 2101 requires that all floor coverings and finishes meet the requirements of the building codes.

Section 2102. Wall Finishes.
Section 2102 requires that wall finishes meet the requirements of the building codes.

Section 2103. Curtains and Draperies.
Section 2103 requires that window treatments in bathrooms and client rooms be arranged in a manner to provide privacy.

Section 2104. Gases.
Section 2104 requires safety precautions when oxygen is being dispensed, administered, or stored. Section 2104 further requires that smoking only be allowed in designated areas in accordance with facility policy.

Section 2105. Furnishings and Equipment.
Section 2105 requires the facility to maintain the physical plant to be free of fire hazards or impediments to fire prevention and prohibits the use of portable electric or unvented fuel heaters.

Section 2200. EXITS
Section 2200 delineates the requirements for facility exits.

Section 2300. WATER SUPPLY AND HYGIENE
Section 2300 title was added for clarity and consistency.

Section 2301. Design and Construction.
Section 2301 delineates the plumbing requirements and required temperatures for hot water.

Section 2302. Cross-connections.
Section 2302 prohibits cross-connections in plumbing between safe and potentially unsafe water supplies.

Section 2400. ELECTRICAL
Section 2400 title was added for clarity and consistency.

Section 2401. Receptacles.
Section 2401 requires that each client room have duplex grounding receptacles located to include one (1) at the head of each bed.

Section 2402. Ground Fault Protection.
Section 2402 requires a ground fault circuit-interrupter for all outside receptacles and bathrooms.

Section 2403. Exit Signs.
Section 2403 requires electrically-illuminated exit signs in facilities licensed for six (6) or more beds.

Section 2404. Emergency Electric Service.
Section 2404 delineates the requirements for emergency electric service to be utilized in times of power outages.

Section 2500. HEATING, VENTILATION, AND AIR CONDITIONING (HVAC)
Section 2500 delineates the installation and maintenance requirements for the facility HVAC system.

Section 2600. PHYSICAL PLANT
Section 2600 title was added for clarity and consistency.

Section 2601. Facility Accommodations and Floor Area.
Section 2601 delineates the required minimum square footage requirements of the facility per licensed bed.

Section 2602. Client Rooms.
Section 2602 delineates the minimum requirements for client rooms. Section 2602 further prohibits more than three (3) beds per client room.

Section 2603. Client Room Floor Area.
Section 2603 requires one hundred (100) square feet for rooms with only one (1) client, and eighty (80) square feet per client in rooms with more than one (1) client.

Section 2604. Bathrooms and Restrooms.
Section 2604 requires the facility to have one (1) toilet for each six (6) licensed beds or a fraction thereof, and further delineates the remaining requirements for bathrooms and restrooms.

Section 2605. Doors.
Section 2605 requires that bathroom, restroom, and client room door widths be at least thirty-six (36) inches wide.

Section 2606. Ramps.
Section 2606 requires the facility to have at least one (1) exterior ramp accessible by all clients, staff members, volunteers, and visitors.

Section 2607. Screens.
Section 2607 requires that windows, doors, and openings intended for ventilation be provided with insect screens.

Section 2608. Windows and Mirrors.
Section 2608 delineates the requirements for windows and mirrors.

Section 2609. Janitor's Closet.
Section 2609 requires the facility to have a lockable janitor's closet equipped with a mop sink or receptor and space for the storage of supplies and equipment.

Section 2610. Storage Areas.
Section 2610 requires the facility to have general storage areas for client, staff, and volunteer belongings, equipment, and supplies. Section 2610 further requires that storage buildings on the premises meet building codes requirements regarding distance from the licensed building.

Section 2611. Telephone Service.
Section 2611 requires at least one (1) telephone on each floor of the facility.

Section 2612. Location.
Section 2612 delineates the requirements for transportation routes to the facility, parking, and access to firefighting equipment.

Section 2613. Outdoor Area.
Section 2613 delineates certain areas which must be enclosed by a fence or natural barrier.

Section 2700. SEVERABILITY
Section 2700 was added to allow the regulation to remain valid should it be determined that a portion of the regulation be invalid or unenforceable.

Section 2800. GENERAL
Section 2800 was added to allow the Department to utilize best practices to manage any conditions not covered by these regulations.

Notice of Public Hearing and Opportunity for Public Comment:

Interested persons may submit written comments on the proposed new regulation by writing Gwen Thompson by mail at Bureau of Health Facilities Licensing, South Carolina Department of Health and Environmental Control, 2600 Bull Street, Columbia, SC 29201; by fax at (803) 545-4212; or by email at HealthRegComm@dhec.sc.gov. Comments may also be submitted electronically on the Public Comments for Health Regulations page at the following address: http://www.scdhec.gov/Agency/RegulationsAndUpdates/PublicComments/. To be considered, comments must be received no later than 5:00 p.m. on February 26, 2018, the close of the public comment period.

Interested persons may also make oral and/or written comments on the proposed new regulation at a public hearing to be conducted by the Board of Health and Environmental Control at its regularly scheduled meeting on March 8, 2018. The meeting will commence at 10:00 a.m. in the Board Room, Third floor, Aycock Building of the Department of Health and Environmental Control; 2600 Bull Street; Columbia, South Carolina 29201. The order of presentation for public hearings will appear in the Board's agenda published by the Department twenty-four (24) hours in advance of the meeting at the following address: http://www.scdhec.gov/Agency/docs/AGENDA.PDF. Persons desiring to make comments at the public hearing are asked to limit their statements to five (5) minutes or less and, as a courtesy, may provide written copies of their presentations for the record. Due to admittance procedures at the DHEC Building, all visitors should enter through the Bull Street entrance and register at the front desk.

The DHEC Regulation Development Update (accessible at http://www.scdhec.gov/Agency/RegulationsAndUpdates/RegulationDevelopmentUpdate/) provides a summary of the proposed new regulation, a link to the proposed new regulation, and applicable contact information. Interested persons may also obtain a copy of the proposed new regulation by contacting Gwen Thompson at the above mailing address or by email at HealthRegComm@dhec.sc.gov.

Preliminary Fiscal Impact Statement:

As noted in the Fiscal Impact Statement for Senate Bill 354 requested by the Senate Medical Affairs committee, the Department estimates an expenditure impact of nine thousand thirty-nine dollars ($9,039) in operating expenses, with an additional expenditure of one thousand twelve dollars ($1,012) in the first year for office equipment. However, the Office of Revenue and Fiscal Affairs anticipates that the Department will accomplish these tasks within the current Other Funds spending authority for the facility licensing program.

Statement of Need and Reasonableness:

The following is based on an analysis of the factors listed in 1976 Code Sections 1-23-115(C)(1)-(3) and (9)-(11):

DESCRIPTION OF REGULATION: Proposed new Regulation 61-125, Standards for Licensing Crisis Stabilization Unit Facilities.

Purpose: The purpose of this new regulation is to establish a process of licensing and regulating Crisis Stabilization Unit ("CSU") Facilities. These facilities, operated by the S.C. Department of Mental Health ("SCDMH"), or in partnership with SCDMH, provide a short-term residential program offering psychiatric stabilization services and brief, intensive crisis services to individuals eighteen (18) years of age or older, twenty-four (24) hours a day, seven (7) days a week.

Legal Authority: 1976 Code Section 44-7-260.

Plan for Implementation: The DHEC Regulation Development Update (accessible at http://www.scdhec.gov/Agency/RegulationsAndUpdates/RegulationDevelopmentUpdate/) provides a summary

of and link to this proposed new regulation. Additionally, printed copies are available for a fee from the Department's Freedom of Information Office. Upon taking legal effect, Department personnel will take appropriate steps to inform the regulated community of the new regulation and any associated information.

DETERMINATION OF NEED AND REASONABLENESS OF THE PROPOSED REGULATION BASED ON ALL FACTORS HEREIN AND EXPECTED BENEFITS:

This proposed new regulation is necessary to execute Act No. 10 amending Article 3 of Chapter 7, Title 44 requiring the Department to license and regulate Crisis Stabilization Unit Facilities. These facilities provide a short-term residential program, offering psychiatric stabilization services and brief, intensive crisis services to individuals eighteen (18) years of age or older, twenty-four (24) hours a day, seven (7) days a week.

DETERMINATION OF COSTS AND BENEFITS:

As noted in the Fiscal Impact Statement for Senate Bill 354 requested by the Senate Medical Affairs committee, the Department estimates an expenditure impact of nine thousand thirty-nine dollars ($9,039) in operating expenses, with an additional expenditure of one thousand twelve dollars ($1,012) in the first year for office equipment. However, the Office of Revenue and Fiscal Affairs anticipates that the Department will accomplish these tasks within the current Other Funds spending authority for the facility licensing program. CSU licensees will pay a licensure fee of ten dollars ($10.00) per licensed bed or seventy-five dollars ($75.00), whichever is greater.

UNCERTAINTIES OF ESTIMATES:

None.

EFFECT ON ENVIRONMENT AND PUBLIC HEALTH:

The proposed regulation seeks to support the Department's goals relating to protection of public health through the anticipated benefits highlighted above. There is no anticipated effect on the environment.

DETRIMENTAL EFFECT ON THE ENVIRONMENT AND PUBLIC HEALTH IF THE REGULATION IS NOT IMPLEMENTED:

There is no anticipated detrimental effect on the environment. If the proposed regulation is not implemented, there would be no mechanism to license and regulate Crisis Stabilization Unit Facilities.

Statement of Rationale:

The Department proposes a new regulation to establish licensure and regulatory requirements for Crisis Stabilization Unit Facilities. These facilities provide a short-term residential program, offering psychiatric stabilization services and brief, intensive crisis services to individuals eighteen (18) years of age or older, twenty-four (24) hours a day, seven (7) days a week.

Text:

The full text of this regulation is available on the South Carolina General Assembly Home Page: **http://www.scstatehouse.gov/regnsrch.php.** Full text may also be obtained from the promulgating agency.

Document No. 4804
DEPARTMENT OF INSURANCE
CHAPTER 69
Statutory Authority: 1976 Code Sections 1-23-110 et seq., 38-3-110, and 38-17-530

69-46. Medicare Supplement Insurance.

Synopsis:

The South Carolina Department of Insurance proposes amendments to Regulation 69-46 to comply with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This legislation is being modified to prohibit the sale of Medigap policies to newly eligible Medicare beneficiaries. Issuers violating this new prohibition after January 1, 2020 are subject to fines and imprisonment of not more than five (5) years. The amendments to this regulation will be based upon the National Association of Insurance Commissioners (NAIC) Model Regulation which has been drafted to implement these changes.

The Notice of Drafting regarding this regulation was published in the *State Register* on September 22, 2017.

Instructions:

Replace Regulation as shown below. All other items and sections remain unchanged.

Text:

69-46. Medicare Supplement Insurance.

(Statutory Authority: 1976 Code Sections 1-23-110 et seq., 38-3-110, and 38-17-530)

Table of Contents

Section 1. Purpose

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

Section 2. Authority

This regulation is issued pursuant to the authority vested in the director under S.C. Code Sections 38-3-110(2), 38-71-530(b) and 1-23-10 et seq.

Section 3. Applicability and Scope

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

(1) All Medicare Supplement policies delivered or issued for delivery in this state on or after the effective date of this regulation; and

(2) All certificates issued under group Medicare Supplement policies, which certificates have been delivered or issued for delivery in this state.

B. This regulation shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

Section 4. Definitions

For purposes of this regulation:

A. "Applicant" means:

(1) In the case of an individual Medicare Supplement policy, the person who seeks to contract for insurance benefits; and

(2) In the case of a group Medicare Supplement policy, the proposed certificate holder.

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

C. "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare Supplement policy.

D. “Certificate form” means the form on which the certificate is delivered or issued for delivery by the issuer.

E. “Continuous period of creditable coverage” means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

F. “Creditable coverage”

(1) “Creditable coverage” means, with respect to an individual, coverage of the individual provided under any of the following:

(a) A group health plan;

(b) Health insurance coverage;

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

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

(e) Chapter 55 Title 10 of the United States Code (CHAMPUS);

(f) A medical care program of the Indian Health Service or of a tribal organization;

(g) A state health benefits risk pool, including the South Carolina Health Insurance Pool;

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

(i) A public health plan as defined in federal regulations; and

(j) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(2) “Creditable coverage” shall not include one or more, or any combination of, the following:

(a) Coverage only for accident or disability income insurance, or any combination of accident and disability income insurance;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers’ compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics; and

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

(3) “Creditable coverage” shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

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

(c) Such other similar, limited benefits as are specified in federal regulations.

(4) “Creditable coverage” shall not include the following benefits if offered as independent, non-coordinated benefits:

(a) Coverage only for a specified disease or illness; and

(b) Hospital indemnity or other fixed indemnity insurance.

(5) “Creditable coverage” shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

(a) Medicare Supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under Chapter 55 Title 10 of the United States Code; and

(c) Similar supplemental coverage provided to coverage under a group health plan.

G. “Employee welfare benefit plan” means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

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

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

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

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

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

(2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and

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

L. "Medicare Supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et. seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. "Medicare Supplement policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act.

M. "Pre-Standardized Medicare Supplement benefit plan," "Pre-Standardized benefit plan" or "Pre-Standardized plan" means a group or individual policy of Medicare Supplement insurance issued prior to May 1, 1992.

N. "1990 Standardized Medicare Supplement benefit plan," "1990 Standardized benefit plan" or "1990 plan" means a group or individual policy of Medicare Supplement insurance issued on or after May 1, 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.

O. "2010 Standardized Medicare Supplement benefit plan," "2010 Standardized benefit plan" or "2010 plan" means a group or individual policy of Medicare Supplement insurance issued with an effective date for coverage on or after June 1, 2010.

P. "Policy ~~form~~" means the form on which the policy is delivered or issued for delivery by the issuer.

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

Section 5. Policy Definitions and Terms

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

A. "Accident," "accidental injury," or "accidental means" shall be defined to employ "result" language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

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

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

B. "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

C. "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

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

E. "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

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

G. "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

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

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

Section 6. Policy Provisions

A. Except for permitted preexisting condition clauses as described in Section 7A(1), Section 8A(1), and Section 8.1A(1) of this regulation, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare Supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

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

C. No Medicare Supplement policy or certificate in force in the state shall contain benefits that duplicate benefits provided by Medicare.

D.(1) Subject to Sections 7A(4), (5) and (7), and 8A(4) and (5), 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) A Medicare Supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

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

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

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

Section 7. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to May 1, 1992

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare Supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

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

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

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

(3) A Medicare Supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

(4) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare Supplement policy shall not:

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

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

(5)(a) Except as authorized by the director of this state, an issuer shall neither cancel nor nonrenew a Medicare Supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(b) If a group Medicare Supplement insurance policy is terminated by the group policyholder and not replaced as provided in Paragraph (5)(d), the issuer shall offer certificate holders an individual Medicare Supplement policy. The issuer shall offer the certificate holder at least the following choices:

(i) An individual Medicare Supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare Supplement policy; and

(ii) An individual Medicare Supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Section 8.1B of this regulation.

(c) If membership in a group is terminated, the issuer shall:

(i) Offer the certificate holder the conversion opportunities described in Subparagraph (b); or

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

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

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

(7) If a Medicare Supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

B. Minimum Benefit Standards.

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

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

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

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

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

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

(7) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless

replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

Section 8. Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued or Delivered on or After May 1, 1992 and With an Effective Date for Coverage Prior to June 1, 2010

The following standards are applicable to all Medicare Supplement policies or certificates delivered or issued for delivery in this state on or after May 1, 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.

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

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

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

(3) A Medicare Supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

(4) No Medicare Supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare Supplement policy shall be guaranteed renewable.

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

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

(c) If the Medicare Supplement policy is terminated by the group policyholder and is not replaced as provided under Section 8A(5)(e), the issuer shall offer certificate holders an individual Medicare Supplement policy which (at the option of the certificate holder):

(i) Provides for continuation of the benefits contained in the group policy; or

(ii) Provides for benefits that otherwise meet the requirements of this subsection.

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

(i) Offer the certificate holder the conversion opportunity described in Section 8A(5)(c); or

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

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

(f) If a Medicare Supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

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

(7)(a) A Medicare Supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not

to exceed twenty-four (24) months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

(b) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted as of the termination of entitlement if the policyholder or certificate holder 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.

(c) Each Medicare Supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

(d) Reinstitution of coverages as described in Subparagraphs (b) and (c):

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

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

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

(8) If an issuer makes a written offer to the Medicare Supplement policyholders or certificate holders of one or more of its plans, to exchange during a specified period from his or her 1990 Standardized plan (as described in Section 9 of this regulation) to a 2010 Standardized plan (as described in Section 9.1 of this regulation), the offer and subsequent exchange shall comply with the following requirements:

(a) An issuer need not provide justification to the director 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. 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 director.

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

(c) An issuer may not apply new preexisting condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 Standardized policy or certificate of the insured, but may apply preexisting condition limitations of no more than six (6) months to any added benefits contained in the new 2010 Standardized policy or certificate not contained in the exchanged policy.

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

B. Standards for Basic (Core) Benefits Common to Benefit Plans A to J. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

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

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

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

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

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

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

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

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

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

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

(5) One Hundred Percent (100%) 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.

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

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

(8) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of $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.

(9)(a) Preventive Medical Care Benefit: Coverage for the following preventive health services not covered by Medicare:

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

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

(b) Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

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

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

(i) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(ii) "Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses' registry.

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

(iv) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four hour period of services provided by a care provider is one visit.

(b) Coverage Requirements and Limitations.

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

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

(iii) Coverage is limited to:

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

(II) The actual charges for each visit up to a maximum reimbursement of $40 per visit;

(III) $1,600 per calendar year;

(IV) Seven (7) visits in any one week;

(V) Care furnished on a visiting basis in the insured's home;

(VI) Services provided by a care provider as defined in this section;

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

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

(c) Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government programs; and

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

D. Standards for Plans K and L.

(1) Standardized Medicare Supplement benefit plan "K" shall consist of the following:

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

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

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

(d) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph (j);

(e) Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing

facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph (j);

(f) Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of- pocket limitation is met as described in Subparagraph (j);

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

(h) Except for coverage provided in Subparagraph (i) below, coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subparagraph (j) below;

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

(j) Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(2) Standardized Medicare Supplement benefit plan "L" shall consist of the following:

(a) The benefits described in Paragraphs (1)(a), (b), (c) and (i);

(b) The benefit described in Paragraphs (1)(d), (e), (f), (g) and (h), but substituting seventy-five percent (75%) for fifty percent (50%); and

(c) The benefit described in Paragraph (1)(j), but substituting $2000 for $4000.

Section 8.1. 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

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 the effective date of these 2010 Standardized Medicare Supplement benefit plan standards in this state. Benefit 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 Section 8 of this regulation.

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

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

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

(3) A Medicare Supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

(4) No Medicare Supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare Supplement policy shall be guaranteed renewable.

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

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

(c) If the Medicare Supplement policy is terminated by the group policyholder and is not replaced as provided under Section 8.1A(5)(e) of this regulation, the issuer shall offer certificateholders an individual Medicare Supplement policy which (at the option of the certificateholder):

(i) Provides for continuation of the benefits contained in the group policy; or

(ii) Provides for benefits that otherwise meet the requirements of this Subsection.

(d) If an individual is a certificateholder in a group Medicare Supplement policy and the individual terminates membership in the group, the issuer shall:

(i) Offer the certificateholder the conversion opportunity described in Section 8.1A(5)(c) of this regulation; or

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

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

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

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

(b) If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted 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.

(c) Each Medicare Supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss.

(d) Reinstitution of coverages as described in Subparagraphs (b) and (c):

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

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

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

B. 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.

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

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

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

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

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

(6) Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

C. 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 Section 9.1 of this regulation.

(1) Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

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

(4) Medicare Part B Deductible: Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(5) One Hundred Percent (100%) 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.

(6) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of $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.

Section 9. Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After May 1, 1992 and With an Effective Date for Coverage Prior to June 1, 2010

A. An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic core benefits, as defined in Section 8B of this regulation.

B. No groups, packages or combinations of Medicare Supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Section 9G and in Section 10 of this regulation.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "L" listed in this subsection and conform to the definitions in Section 4 of this regulation. Each benefit shall be structured in accordance with the format provided in Sections 8B and 8C, or 8D and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. An issuer may use, in addition to the benefit plan designations required in Subsection C, other designations to the extent permitted by law.

E. Make-up of benefit plans:

(1) Standardized Medicare Supplement benefit plan "A" shall be limited to the basic (core) benefits common to all benefit plans, as defined in Section 8B of this regulation.

(2) Standardized Medicare Supplement benefit plan "B" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible as defined in Section 8C(1).

(3) Standardized Medicare Supplement benefit plan "C" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (3) and (8) respectively.

(4) Standardized Medicare Supplement benefit plan "D" shall include only the following: The core benefit (as defined in Section 8B of this regulation), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in an foreign country and the at-home recovery benefit as defined in Sections 8C(1), (2), (8) and (10) respectively.

(5) Standardized Medicare Supplement benefit plan "E" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in Sections 8C(1), (2), (8) and (9) respectively.

(6) Standardized Medicare Supplement benefit plan "F" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (3), (5) and (8) respectively.

(7) Standardized Medicare Supplement benefit high deductible plan "F" shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (3), (5) and (8) respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare Supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be $1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(8) Standardized Medicare Supplement benefit plan "G" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent (80%) of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in Sections 8C(1), (2), (4), (8) and (10) respectively.

(9) Standardized Medicare Supplement benefit plan "H" shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (6) and (8) respectively. The outpatient prescription drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005.

(10) Standardized Medicare Supplement benefit plan "I" shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in Sections 8C(1), (2), (5), (6), (8) and (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005.

(11) Standardized Medicare Supplement benefit plan "J" shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in Sections 8C(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005.

(12) Standardized Medicare Supplement benefit high deductible plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in Sections 8C(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare Supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10. The outpatient prescription drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005.

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

(1) Standardized Medicare Supplement benefit plan "K" shall consist of only those benefits described in Section 8D(1).

(2) Standardized Medicare Supplement benefit plan "L" shall consist of only those benefits described in Section 8D(2).

G. New or Innovative Benefits: An issuer may, with the prior approval of the director, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare Supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of Medicare Supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

Section 9.1. 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

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 Section 9 of this regulation.

A.(1) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic (core) benefits, as defined in Section 8.1B of this regulation.

(2) If an issuer makes available any of the additional benefits described in Section 8.1C, or offers standardized benefit Plans K or L (as described in Sections 9.1E(8) and (9) 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) above, a policy form or certificate form containing either standardized benefit Plan C (as described in Section 9.1E(3) of this regulation) or standardized benefit Plan F (as described in 9.1E(5) of this regulation).

B. No groups, packages or combinations of Medicare Supplement benefits other than those listed in this Section shall be offered for sale in this state, except as may be permitted in Section 9.1F and in Section 10 of this regulation.

C. 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 Section 4 of this regulation. Each benefit shall be structured in accordance with the format provided in Sections 8.1B and 8.1C of this regulation; or, in the case of plans K or L, in Sections 9.1E(8) or (9) 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.

D. In addition to the benefit plan designations required in Subsection C of this section, an issuer may use other designations to the extent permitted by law.

E. Make-up of 2010 Standardized Benefit Plans:

(1) Standardized Medicare Supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in Section 8.1B of this regulation.

(2) Standardized Medicare Supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible as defined in Section 8.1C(1) of this regulation.

(3) Standardized Medicare Supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (4), and (6) of this regulation, respectively.

(4) Standardized Medicare Supplement benefit Plan D shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), and (6) of this regulation, respectively.

(5) Standardized Medicare Supplement regular Plan F shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (4), (5), and (6), respectively.

(6) Standardized Medicare Supplement Plan F With High Deductible shall include only the following: one hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in Subparagraph (b).

(a) The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (4), (5), and (6) of this regulation, respectively.

(b) 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 twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

(7) Standardized Medicare Supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (5), and (6), respectively. Effective January 1, 2020, the standardized benefit plans described in Section 9.2A(4) of this regulation (Redesignated Plan G High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

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

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

(b) Part A Hospital Coinsurance, 91st through 150th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

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

(d) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph (j);

(e) Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph (j);

(f) Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of- pocket limitation is met as described in Subparagraph (j);

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

(h) Part B Cost Sharing: Except for coverage provided in Subparagraph (i), coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subparagraph (j);

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

(j) Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

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

(a) The benefits described in Paragraphs 9.1E(8)(a), (b), (c) and (i);

(b) The benefit described in Paragraphs 9.1E(8)(d), (e), (f), (g) and (h), but substituting seventy-five percent (75%) for fifty percent (50%); and

(c) The benefit described in Paragraph 9.1E(8)(j), but substituting $2000 for $4000.

(10) Standardized Medicare Supplement Plan M shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus fifty percent (50%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(2), (3) and (6) of this regulation, respectively.

(11) Standardized Medicare Supplement Plan N shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3) and (6) of this regulation, respectively, with copayments in the following amounts:

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

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

F. New or Innovative Benefits: An issuer may, with the prior approval of the director, 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.

Section 9.2. Standard Medicare Supplement Benefit Plans for 2020 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery to Individuals Newly Eligible for Medicare on or after January 1, 2020

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of S.C. Code Section 38-71-10 et. seq. and Section 9.1 of this Regulation.

A. Benefit Requirements. The standards and requirements of Section 9.1 shall apply to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:

(1) Standardized Medicare supplement benefit Plan C is redesignated as Plan D and shall provide the benefits contained in Section 9.1E(3) of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.

(2) Standardized Medicare supplement benefit Plan F is redesignated as Plan G and shall provide the benefits contained in Section 9.1E(5) of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.

(3) Standardized Medicare supplement benefit plans C, F, and F with High Deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

(4) Standardized Medicare supplement benefit Plan F With High Deductible is redesignated as Plan G With High Deductible and shall provide the benefits contained in Section 9.1E(6) of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible; provided further that, the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible.

(5) The reference to Plans C or F contained in Section 9.1A(2) is deemed a reference to Plans D or G for purposes of this section.

B. Applicability to Certain Individuals. This Section 9.2, applies to only individuals that are newly eligible for Medicare on or after January 1, 2020:

(1) By reason of attaining age 65 on or after January 1, 2020; or

(2) By reason of entitlement to benefits under part A pursuant to Section 226(b) or 226A of the Social Security Act, or who is deemed to be eligible for benefits under Section 226(a) of the Social Security Act on or after January 1, 2020.

C. Guaranteed Issue for Eligible Persons. For purposes of Section 12.E, in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F With High Deductible) shall be deemed to be a reference to Medicare supplement policy D or G (including G With High Deductible), respectively, that meet the requirements of this Section 9.2A.

D. Applicability to Waivered States. In the case of a State described in Section 1882(p)(6) of the Social Security Act ("waivered" alternative simplification states) MACRA prohibits the coverage of the Medicare Part B deductible for any Medicare supplement policy sold or issued to an individual that is newly eligible for Medicare on or after January 1, 2020.

E. Offer of Redesignated Plans to Individuals Other than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in Subparagraph A(4) above may be offered to any individual who was eligible for Medicare prior to January 1, 2020, in addition to the standardized plans described in Section 9.1E of this regulation.

Section 10. Medicare Select Policies and Certificates

A. (1) This section shall apply to Medicare Select policies and certificates, as defined in this section.

(2) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

B. For the purposes of this section:

(1) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

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

(3) "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

(4) "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare Supplement policy or certificate that contains restricted network provisions.

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

(6) "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) "Service area" means the geographic area approved by the director within which an issuer is authorized to offer a Medicare Select policy.

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

D. A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the director.

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

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

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

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

(i) To deliver adequately all services that are subject to a restricted network provision; or

(ii) To make appropriate referrals.

(c) There are written agreements with network providers describing specific responsibilities.

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

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

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

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

(a) The formal organizational structure;

(b) The written criteria for selection, retention and removal of network providers; and

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

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

(6) Copies of the written information proposed to be used by the issuer to comply with Subsection I.

(7) Any other information requested by the director.

F. (1) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the director prior to implementing the changes. Changes shall be considered approved by the director after thirty (30) days unless specifically disapproved.

(2) An updated list of network providers shall be filed with the director at least quarterly.

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

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

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

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

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

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

(a) Other Medicare Supplement policies or certificates offered by the issuer; and

(b) Other Medicare Select policies or certificates.

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

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

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

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

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

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

J. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection I of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

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

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

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

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

(4) If a grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of a grievance.

(6) The issuer shall report no later than each March 31st to the director regarding its grievance procedure. The report shall be in a format prescribed by the director and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

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

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

(2) For the purposes of this subsection, a Medicare Supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the

Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

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

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

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

O. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

Section 11. Open Enrollment

A. An issuer shall not deny or condition the issuance or effectiveness of any Medicare Supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare Supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

B.(1) If an applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.

(2) If the applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.

C. Except as provided in Subsection B and Sections 12 and 23, Subsection A shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

Section 12. Guaranteed Issue for Eligible Persons

A. Guaranteed Issue.

(1) Eligible persons are those individuals described in Subsection B who seek to enroll under the policy during the period specified in Subsection C, and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare Supplement policy.

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

B. Eligible Persons. An eligible person is an individual described in any of the following paragraphs:

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

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

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

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

(c) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in 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;

(d) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

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

(ii) 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

(e) The individual meets such other exceptional conditions as the Secretary may provide.

(3)(a) The individual is enrolled with:

(i) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost);

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

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

(iv) An organization under a Medicare Select policy; and

(b) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Section 12B(2).

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

(a)(i) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(ii) Of other involuntary termination of coverage or enrollment under the policy;

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

(c) The issuer, or a producer or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.

(5)(a) The individual was enrolled under a Medicare Supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act or a Medicare Select policy; and

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

(6) The individual, upon first becoming eligible for benefits under part A of Medicare at age 65, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment.

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

C. Guaranteed Issue Time Periods.

(1) In the case of an individual described in Subsection B(1), the guaranteed issue period begins on the later of: (i) the date the individual receives a notice of termination or cessation of all Supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or (ii) the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;

(2) In the case of an individual described in Subsection B(2), B(3), B(5) or B(6) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;

(3) In the case of an individual described in Subsection B(4)(a), the guaranteed issue period begins on the earlier of: (i) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated;

(4) In the case of an individual described in Subsection B(2), B(4)(b), B(4)(c), B(5) or B(6) who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date;

(5) In the case of an individual described in Subsection B(7), the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare Supplement issuer during the sixty-day period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

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

D. Extended Medigap Access for Interrupted Trial Periods.

(1) In the case of an individual described in Subsection B(5) (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in Subsection B(5)(a) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 12B(5);

(2) In the case of an individual described in Subsection B(6) (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in Subsection B(6) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 12B(6); and

(3) For purposes of Subsections B(5) and B(6), no enrollment of an individual with an organization or provider described in Subsection B(5)(a), or with a plan or in a program described in Subsection B(6), may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

E. Products to Which Eligible Persons are Entitled. The Medicare Supplement policy to which eligible persons are entitled under:

(1) Section 12B(1), (2), (3) and (4) is a Medicare Supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer;

(2)(a) Subject to Subparagraph (b), Section 12B(5) is the same Medicare Supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Paragraph (1);

(b) After December 31, 2005, if the individual was most recently enrolled in a Medicare Supplement policy with an outpatient prescription drug benefit, a Medicare Supplement policy described in this subparagraph is:

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

(ii) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer;

(3) Section 12B(6) shall include any Medicare Supplement policy offered by any issuer;

(4) Section 12B(7) is a Medicare Supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare Supplement policy with outpatient prescription drug coverage.

F. Notification provisions.

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

(2) At the time of an event described in Subsection B of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare Supplement policies under Section 12A. Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment.

Section 13. Standards for Claims Payment

A. An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:

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

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

(3) Paying the participating physician or supplier directly;

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

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

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

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

Section 14. Loss Ratio Standards and Refund or Credit of Premium

A. Loss Ratio Standards.

(1)(a) A Medicare Supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(i) At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or

(ii) At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies;

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

(i) Home office and overhead costs;
(ii) Advertising costs;
(iii) Commissions and other acquisition costs;
(iv) Taxes;
(v) Capital costs;
(vi) Administrative costs; and
(vii) Claims processing costs.

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

(3) For purposes of applying Subsection A(1) of this section and Subsection C(3) of Section 15 only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

(4) For policies issued prior to May 1, 1992, expected claims in relation to premiums shall meet:

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

(b) The appropriate loss ratio requirement from Subsection A(1)(a)(i) and (ii) when combined with actual experience beginning with July 22, 2005 to date; and

(c) The appropriate loss ratio requirement from Subsection A(1)(a)(i) and (ii) over the entire future period for which the rates are computed to provide coverage.

B. Refund or Credit Calculation.

(1) An issuer shall collect and file with the director by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare Supplement benefit plan.

(2) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare Supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) For the purposes of this section, policies or certificates issued prior to May 1, 1992, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after April 28, 1996. The first report shall be due by May 31, 1998.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for thirteen-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual filing of Premium Rates. An issuer of Medicare Supplement policies and certificates issued before or after the effective date of May 1, 1992 in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the director in accordance with the filing requirements and procedures prescribed by the director. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare Supplement policies or certificates in this state shall file with the director, in accordance with the applicable filing procedures of this state:

(1)(a) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing.

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

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

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

D. Public Hearings. The director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this regulation if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the director.

Section 15. Filing and Approval of Policies and Certificates and Premium Rates

A. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the director in accordance with filing requirements and procedures prescribed by the director.

B. An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the director in the state in which the policy or certificate was issued.

C. An issuer shall not use or change premium rates for a Medicare Supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the director in accordance with the filing requirements and procedures prescribed by the director.

D.(1) Except as provided in Paragraph (2) of this subsection, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare Supplement benefit plan.

(2) An issuer may offer, with the approval of the director, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare Supplement benefit plan, one for each of the following cases:

(a) The inclusion of new or innovative benefits;

(b) The addition of either direct response or agent marketing methods;

(c) The addition of either guaranteed issue or underwritten coverage;

(d) The offering of coverage to individuals eligible for Medicare by reason of disability.

(3) For the purposes of this section, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

E.(1) Except as provided in Paragraph (1)(a), an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the director. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

(a) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the director in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the director, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(b) An issuer that discontinues the availability of a policy form or certificate form pursuant to Subparagraph (a) shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare Supplement benefit plan as the discontinued form for a period of five (5) years after the issuer

provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate.

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

(3) A change in the rating structure or methodology shall be considered a discontinuance under Paragraph (1) unless the issuer complies with the following requirements:

(a) The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(b) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The director may approve a change to the differential that is in the public interest.

F. (1) Except as provided in Paragraph (2), the experience of all policy forms or certificate forms of the same type in a standard Medicare Supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section 14, subsection B.

(2) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

G. An issuer shall not present for filing for approval a rate structure for its Medicare supplement policies or certificates issued after the effective date of the amendment of this regulation based upon a structure or methodology with any groupings of attained ages greater than one year. The ratio between rates for successive ages shall increase smoothly as age increases.

Section 16. Permitted Compensation Arrangements

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

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

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

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

Section 17. Required Disclosure Provisions

A. General Rules.

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

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

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

(4) If a Medicare Supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

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

(6)(a) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and CMS and in a type size no smaller than 12 point type. Delivery of the Guide shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare Supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgement of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

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

B. Notice Requirements.

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

(a) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare Supplement policy or certificate; and

(b) Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

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

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

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

D. Outline of Coverage Requirements for Medicare Supplement Policies.

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

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

(3) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12) point type. All plans A-L shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(4) 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 your state.

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 copayments.

[]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

* 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 [$2200] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$2200]. 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.

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 $[5120]; paid at 100% after limit reached	Out-of-pocket limit $[2560]; paid at 100% after limit reached		

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.]
READ YOUR POLICY VERY CAREFULLY [Boldface Type]
This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.
RIGHT TO RETURN POLICY [Boldface Type]
If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.
POLICY REPLACEMENT [Boldface Type]
If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.
NOTICE [Boldface Type]
This policy may not fully cover all of your medical costs.
[for agents:]
Neither [insert company's name] nor its agents are connected with Medicare.
[for direct response:]
[insert company's name] is not connected with Medicare.
This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.
COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]
When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]
Review the application carefully before you sign it. Be certain that all information has been properly recorded. [Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to Section 9.1D of this regulation.]
[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the director.]

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020
This chart shows the benefits included in each of the standard Medicare supplement plans. Some plan may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: An "✓" means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in [2017][2]					[$5120][2]	[$2560][2]				

1 Plans F and G also have a high deductible option which require first paying a plan deductible of [$2200] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.
2 Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.
3 Plan N pays 100% of the Part B coinsurance, except for co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

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 $[1316]	$0	$[1316](Part A deductible)
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] 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 $[164.50] a day	$0	Up to $[164.50] 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

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

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

*Once you have been billed $[183] 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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN A
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (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 $[1316]	$[1316](Part A deductible)	$0
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] 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 $[164.50] a day	$0	Up to $[164.50] 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

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

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

*Once you have been billed $[183] 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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN B
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (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 $[1316]	$[1316](Part A deductible)	$0
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] 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 $[164.50] a day	Up to $[164.50] 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 copayment/coinsurance	$0

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

PLAN C
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR
Once you have been billed $[183] 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 $[183] of Medicare Approved Amounts*	$0	$[183] (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 $[183] of Medicare Approved Amounts*	$0	$[183] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN C
PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[183] of Medicare Approved Amounts*	$0	$[183] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C
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 $[1316]	$[1316] (Part A deductible)	$0
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] a day $0	$0
- Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[164.50] a day	Up to $[164.50] 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 copayment/ coinsurance	$0

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

PLAN D
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR
Once you have been billed $[183] 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 $[183] of Medicare Approved Amounts*	$0	$0	$[183](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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN D
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD
* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2200] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2200]. 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 $[2200] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2200] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1316]	$[1316] (Part A deductible)	$0
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after:			
While using 60 Lifetime reserve days	All but $[658] a day	$[658] 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 $[164.50] a day	Up to $[164.50] 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 Copayment/coinsurance	$0

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

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR
*Once you have been billed $[183] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.
[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2200] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2200]. 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 $[2200] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2200] 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 $[183] of Medicare Approved Amounts*	$0	$[183] (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 $[183] of Medicare			
Approved Amounts*	$0	$[183] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES--TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN F or HIGH DEDUCTIBLE PLAN F
PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2200] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2200] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[183] of			
Medicare Approved Amounts*	$0	$[183] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2200] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2200] 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 or HIGH DEDUCTIBLE 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.

[**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [$2200] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [$2200]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2200] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2200] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1316]	$[1316] (Part A deductible)	$0
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] 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 $[164.50] a day	Up to $[164.50] 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 copayment/ coinsurance	$0

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

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

*Once you have been billed $[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [$2200] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [$2200]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2200] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2200] 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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Unless Part B deductible has been met)
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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN G or HIGH DEDUCTIBLE PLAN G
PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $2200] DEDUCTIBLE,]** PLAN PAYS	[IN ADDITION TO $[2200] DEDUCTIBLE,]** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN G or HIGH DEDUCTIBLE PLAN G
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $2200] DEDUCTIBLE,]** PLAN PAYS	[IN ADDITION TO $[2200] 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 K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[5120] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD
** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1316]	$[658](50% of Part A deductible)	$[658](50% of Part A deductible) ♦
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] 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 $[154.50] a day	Up to $[82.25] a day (50% of Part A Coinsurance)	Up to $[82.25]a day (50% of Part A Coinsurance) ♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50% ♦
Additional amounts	100%	$0	$0
HOSPICE CARE	All but very limited		
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	copayment/coinsurance for out-patient drugs and inpatient respite care	50% of copayment/coinsurance	50% of Medicare copayment/coinsurance ♦

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

PLAN K
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR
**** Once you have been billed $[183] 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 $[183] of Medicare Approved Amounts****	$0	$0	$[183] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 80% 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 [$5120])*
BLOOD			
First 3 pints	$0	50%	50% ♦
Next $[183] of Medicare Approved Amounts****	$0	$0	$[183] (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 $[5120] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[183] of Medicare Approved Amounts*****	$0	$0	$[183] (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 $[2560] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD
** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1316]	$[987] (75% of Part A deductible)	$[329] (25% of Part A deductible) ♦
61st thru 90th day	All but $[329] a day	$[329] a day	$[329] (25% of Part A deductible) ♦
91st day and after:			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] 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 $[164.50] a day	Up to $[123.38] a day (75% of Part A Coinsurance)	Up to $[41.13] a day (25% of Part A Coinsurance) ♦
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 requirement, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	75% of copayment/coinsurance	25% of copayment/coinsurance ♦

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

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

**** Once you have been billed $[183] 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 $[183] of Medicare Approved Amounts****	$0	$0	$[183] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 80% 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 [$2560])*
BLOOD			
First 3 pints	$0	75%	25% ♦
Next $[183] of Medicare Approved Amounts****	$0	$0	$[183] (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 $[2560] 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 & 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 $[183] of Medicare Approved Amounts*****	$0	$0	$[183] (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 $[1316]	$[658] (50% of Part A deductible)	$[658] (50% of Part A deductible)
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] 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 $[164.50] a day	Up to $[164.50] 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 requirement, 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

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

PLAN M
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR
* Once you have been billed $[183] 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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)

Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN M
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[183] of Medicare Approved Amounts	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN 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 $[1316]	$[1316] (Part A deductible)	$0
61st thru 90th day	All but $[329] a day	$[329] a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but $[658] a day	$[658] 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 $[164.50] a day	Up to $[164.50] 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 requirement, 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

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

PLAN N
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR
**** Once you have been billed $[183] 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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (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 copayment 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 copayment 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 $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[183] of Medicare Approved Amounts*	$0	$0	$[183] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN N
OTHER BENEFITS - NOT COVERED BY MEDICARE

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

E. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

(1) Any accident and sickness insurance policy or certificate, other than a Medicare Supplement policy, a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. Section 1395 et seq.), disability income policy; or other policy identified in Section 3B of this regulation, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare Supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve (12) point type and shall contain the following language:

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

(2) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Subsection D(1) shall disclose, using the applicable statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

Section 18. 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 another health insurance policy or certificate in force or whether a Medicare Supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A Supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

[Statements]

(1) You do not need more than one Medicare Supplement policy.

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

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

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are

no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

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

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

[Questions]

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

[Please mark Yes or No below with an "X"]

To the best of your knowledge,

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

Yes___ No___

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

Yes___ No___

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

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

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

Yes___ No___

If yes,

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

Yes___ No___

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

Yes___ No___

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

START _/_/_ END _/_/_

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

Yes___ No___

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

Yes___ No___

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

Yes___ No___

(4) (a) Do you have another Medicare Supplement policy in force?
Yes___ No___
(b) If so, with what company, and what plan do you have [optional for Direct Mailers]?
_____
(c) If so, do you intend to replace your current Medicare Supplement policy with this policy?
Yes___ No___
(5) Have you had coverage under any other health insurance within the past 63 days?
(For example, an employer, union, or individual plan)
Yes___ No___
(a) If so, with what company and what kind of policy?
_____
_____
_____
_____
(b) What are your dates of coverage under the other policy?
START _/_/_ END _/_/_
(If you are still covered under the other policy, leave "END" blank.)

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

(1) List policies sold which are still in force.

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

C. In the case of a direct response issuer, a copy of the application or Supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

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

E. The notice required by Subsection D above for an issuer shall be provided in substantially the following form in no less than twelve (12) point type:

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

[Insurance company's name and address]

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

According to [your application] [information you have furnished], you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

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

___Additional benefits.
___No change in benefits, but lower premiums.
___Fewer benefits and lower premiums.
___My plan has outpatient prescription drug coverage and I am enrolling in Part D.

___Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. [optional only for Direct Mailers.]
___Other. (please specify) _____
1. Note: If the issuer of the Medicare Supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]
Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
(Signature of Agent, Broker or Other Representative)*
[Typed Name and Address of Issuer, Agent or Broker]

_____
(Applicant's Signature)

_____
(Date)
*Signature not required for direct response sales.

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

Section 19. Filing Requirements for Advertising

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

Section 20. Standards for Marketing

A. An issuer, directly or through its producers, shall:

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

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

"Notice to buyer: This policy may not cover all of your medical expenses."

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare Supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

(5) Establish auditable procedures for verifying compliance with this Subsection A.

B. In addition to the practices prohibited in S.C. Code Sections 38-57-10 et seq, the following acts and practices are prohibited:

(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit,

surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy or to take out a policy of insurance with another insurer.

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

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

C. The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this regulation.

Section 21. Appropriateness of Recommended Purchase and Excessive Insurance

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

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

C. An issuer shall not issue a Medicare Supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

Section 22. Reporting of Multiple Policies

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

(1) Policy and certificate number; and

(2) Date of issuance.

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

Section 23. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates

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

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

Section 24. Prohibition Against Use of Genetic Information and Requests for Genetic Testing

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

A. An issuer of a Medicare Supplement policy or certificate;

1. 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 preexisting condition) on the basis of the genetic information with respect to such individual; and

2. 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.

B. Nothing in Subsection A shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:

1. Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

2. Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under 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).

C. 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.

D. Subsection C 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.

E. For purposes of carrying out Subsection D, an issuer of a Medicare Supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

F. Notwithstanding Subsection C, 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:

(1) 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.

(2) 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:

(a) compliance with the request is voluntary; and

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

(3) 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.

(4) 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.

(5) The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this Subsection.

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

H. 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.

I. 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 H if such request, requirement, or purchase is not in violation of Subsection G.

J. For the purposes of this Section only:

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

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

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

(4) "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

(5) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of

proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(6) "Underwriting purposes" means:

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

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

(c) the application of any preexisting condition exclusion under the policy; and

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

Section 25. Severability

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

Section 26. Effective Date

This regulation shall be effective upon publication in the State Register.

APPENDIX A. MEDICARE SUPPLEMENT REFUND CALCULATION FORM

FOR CALENDAR YEAR	
TYPE[1]	SMSBP[2]
For the State of	Company Name
NAIC Group Code	NAIC Company Code
Address	Person Conducting Exhibit
Title	Telephone Number

Line			(a) Earned Premium[3]	(b) Incurred Claims[4]
1.	Current Years' Experience			
		a. Total (all policy years)		
		b. Current year's issues[5]		
		c. Net (for reporting purposes = 1a-1b		
2.	Past Years' Experience (all policy years)			
3.	Total Experience (Net Current Year + Past Year)			
4.	Refunds Last Year (Excluding Interest)			
5.	Previous Since Inception (Excluding Interest)			
6.	Refunds Since Inception (Excluding Interest)			
7.	Benchmark Ratio Since Inception *(see worksheet for Ratio 1)*			
8.	Experienced Ratio Since Inception (Ratio 2)			
		Total Actual Incurred Claims (line 3, col. b)		
		Total Earned Prem. (line 3, col. a)-Refunds Since Inception (line 6)		
9.	Life Years Exposed Since Inception			
	If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.			
10.	Tolerance Permitted (obtained from credibility table)			

Medicare Supplement Credibility Table

Life Years Exposed	
Since Inception	Tolerance
10,000+	0.0%
5,000 – 9,999	5.0%
2,500 – 4,999	7.5%
1,000 – 2,499	10.0%
500 – 999	15.0%
If less than 500, no credibility	

11.	Adjustment to Incurred Claims for Credibility
	Ratio 3 = Ratio 2 + Tolerance

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.
If Ratio 3 is less than the Benchmark Ratio, then proceed.

12.	Adjusted Incurred Claims	
	[Total Earned Premiums (line 3, col. a)-Refunds Since Inception (line 6)] x Ratio 3 (line 11)	
13.	Refund = Total Earned Premiums (line 3, col. a)-Refunds Since Inception (line 6) -[Adjusted Incurred Claims (line 12)/Benchmark Ratio (Ratio 1)]	

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
2 ”SMSBP” = Standardized Medicare Supplement Benefit Plan - Use “P” for pre-standardized plans.
3 ncludes Modal Loadings and Fees Charged.
4 Excludes Active Life Reserves.
5 This is to be used as “Issue Year Earned Premium” for Year 1 of next year’s “Worksheet for Calculation of Benchmark Ratios”.

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES

FOR CALENDAR YEAR	
TYPE[1]	SMSBP[2]
For the State of	Company Name
NAIC Group Code	NAIC Company Code
Address	Person Conducting Exhibit
Title	Telephone Number

(a)3	(b)4	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)5
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15+[6]		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
2 “SMSBP” = Standardized Medicare Supplement Benefit Plan - Use “P” for pre-standardized plans.
3 Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.).
4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.
6 To include the earned premium for all years prior to as well as the 15th year prior to the current year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK

RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES

FOR CALENDAR YEAR _____

TYPE1										
For the State of						SMSBP[2]				
Company Name						Company Name				
NAIC Group Code						NAIC Company Code				
Address						Person Conducting Exhibit				
Title						Telephone Number				
(a)3	(b)4	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)5
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+6		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	
Benchmark Ratio Since Inception: (l + n)/(k + m): _____										

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
2 ”SMSBP” = Standardized Medicare Supplement Benefit Plan - Use “P” for pre-standardized plans.
3 Year 1 is the current calendar year – 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.).
4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.
6 To include the earned premium for all years prior to as well as the 15th year prior to the current year.

APPENDIX B. FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES
Company Name: _____
Address: _____
_____
Phone Number: _____
Due March 1, annually
The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare Supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

APPENDIX C. DISCLOSURE STATEMENTS
Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare
1. Section 1882 (d) of the federal Social Security Act, 42 U.S.C. 1395ss, prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.
2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).
3. State and federal law prohibits insurers from selling a Medicare Supplement policy to a person that already has a Medicare Supplement policy except as a replacement policy.
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not preempt state laws that are more stringent than the federal requirements.
8. The federal law does not preempt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously. [Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]
IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS
This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

[]hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

[]hospitalization

[]physician services

[][outpatient prescription drugs if you are enrolled in Medicare Part D]

[]other approved items and services

Before You Buy This Insurance

✓Check the coverage in all health insurance policies you already have.

✓For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

✓For help in understanding your health insurance, contact your state insurance department.

[Original disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

[]any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

[]hospitalization

[]physician services

[][outpatient prescription drugs if you are enrolled in Medicare Part D]

[]other approved items and services

Before You Buy This Insurance

✓Check the coverage in all health insurance policies you already have.

✓For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

✓For help in understanding your health insurance, contact your state insurance department.

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

[]hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

[]hospitalization

[]physician services

[]hospice
[][outpatient prescription drugs if you are enrolled in Medicare Part D]
[]other approved items and services
Before You Buy This Insurance
✓Check the coverage in all health insurance policies you already have.
✓For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
✓For help in understanding your health insurance, contact your state insurance department.
[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]
IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS
This is not Medicare Supplement Insurance
This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.
This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
[]hospitalization
[]physician services
[]hospice
[][outpatient prescription drugs if you are enrolled in Medicare Part D]
[]other approved items and services
Before You Buy This Insurance
✓Check the coverage in all health insurance policies you already have.
✓For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
✓For help in understanding your health insurance, contact your state insurance department.
[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]
IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS
This is not Medicare Supplement Insurance
This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.
This insurance duplicates Medicare benefits when:
[]any expenses or services covered by the policy are also covered by Medicare
Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
[]hospitalization
[]physician services
[][outpatient prescription drugs if you are enrolled in Medicare Part D]
[]hospice
[]other approved items and services
Before You Buy This Insurance
✓Check the coverage in all health insurance policies you already have.
✓For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

✓For help in understanding your health insurance, contact your state insurance department.
[Original disclosure statement for policies that provide benefits upon both an expense incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS
This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:
[]any expenses or services covered by the policy are also covered by Medicare; or
[]it pays the fixed dollar amount stated in the policy and Medicare covers the same event
Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
[]hospitalization
[]physician services
[]hospice care
[][outpatient prescription drugs if you are enrolled in Medicare Part D]
[]other approved items & services

Before You Buy This Insurance
✓Check the coverage in all health insurance policies you already have.
✓For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
✓For help in understanding your health insurance, contact your state insurance department.
[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS
This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:
[]the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
[]hospitalization
[]physician services
[]hospice
[][outpatient prescription drugs if you are enrolled in Medicare Part D]
[]other approved items and services

Before You Buy This Insurance
✓Check the coverage in all health insurance policies you already have.
✓For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
✓For help in understanding your health insurance, contact your state insurance department
[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

[]hospitalization

[]physician services

[][outpatient prescription drugs if you are enrolled in Medicare Part D]

[]other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

✓Check the coverage in all health insurance policies you already have.

✓For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

✓For help in understanding your health insurance, contact your state insurance department.

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

[]hospitalization

[]physician services

[][outpatient prescription drugs if you are enrolled in Medicare Part D]

[]other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

✓Check the coverage in all health insurance policies you already have.

✓For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

✓For help in understanding your health insurance, contact your state insurance department.

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

[]hospitalization

[]physician services

[]hospice

[][outpatient prescription drugs if you are enrolled in Medicare Part D]
[]other approved items and services
This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.
Before You Buy This Insurance
✓Check the coverage in all health insurance policies you already have.
✓For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
✓For help in understanding your health insurance, contact your state insurance department.
[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]
IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE
Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
[]hospitalization
[]physician services
[]hospice
[][outpatient prescription drugs if you are enrolled in Medicare Part D]
[]other approved items and services
This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.
Before You Buy This Insurance
✓Check the coverage in all health insurance policies you already have.
✓For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
✓For help in understanding your health insurance, contact your state insurance department.
[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]
IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE
Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.
Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
[]hospitalization
[]physician services
[]hospice
[][outpatient prescription drugs if you are enrolled in Medicare Part D]
[]other approved items and services
This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.
Before You Buy This Insurance
✓Check the coverage in all health insurance policies you already have.

✓For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
✓For help in understanding your health insurance, contact your state insurance department.
[Alternative disclosure statement for policies that provide benefits upon both an expense incurred and fixed indemnity basis.]
IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE
Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.
Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
[]hospitalization
[]physician services
[]hospice care
[][outpatient prescription drugs if you are enrolled in Medicare Part D]
[]other approved items & services
This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.
Before You Buy This Insurance
✓Check the coverage in all health insurance policies you already have.
✓For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
✓For help in understanding your health insurance, contact your state insurance department.
[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]
IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE
Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.
Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:
[]hospitalization
[]physician services
[]hospice
[][outpatient prescription drugs if you are enrolled in Medicare Part D]
[]other approved items and services
This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.
Before You Buy This Insurance
✓Check the coverage in all health insurance policies you already have.
✓For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
✓For help in understanding your health insurance, contact your state insurance department.

Document No. 4805
DEPARTMENT OF INSURANCE
CHAPTER 69
Statutory Authority: 1976 Code Sections 1-23-110 et seq., 38-3-110, and Title V of Pub. Law 102-106, the Gramm-Leach-Bliley Act

69-58. Privacy of Consumer Financial and Health Information.

Synopsis:

The South Carolina Department of Insurance proposes to amend Regulation 69-58 to comply with the amendments to the Annual Notice requirements of Article V of the Gramm Leach Bliley Act included in the Fixing America's Surface Transportation Act (FAST Act) and the most recent NAIC model law and regulation. The FAST Act eliminates the annual privacy notice requirements for financial institutions under certain circumstances. The amendments to Regulation 69-58 will comport with the most recent version of the NAIC Privacy of Consumer Financial Information model which incorporates these amendments.

The Notice of Drafting regarding this regulation was published on September 22, 2017 in the *State Register*.

Instructions:

Replace Regulation as shown below. All other items and sections remain unchanged.

Text:

69-58. Privacy of Consumer Financial and Health Information.

(Statutory Authority: 1976 Code Sections 1-23-110 et seq., 38-3-110, and Title V of Pub. Law 102-106, the Gramm-Leach-Bliley Act)

Table of Contents

ARTICLE I
GENERAL PROVISIONS

Section 1. Authority.

This regulation is promulgated pursuant to the authority granted by Sections 38-3-110 of the South Carolina Insurance Code and Title V of Pub. Law 102-106, the Gramm-Leach-Bliley Act.

Section 2. Purpose and Scope.

A. Purpose.

This regulation governs the treatment of nonpublic personal health information and nonpublic personal financial information about individuals by all licensees of the state insurance department. This regulation:

(1) Requires a licensee to provide notice to individuals about its privacy policies and practices;

(2) Describes the conditions under which a licensee may disclose nonpublic personal health information and nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties; and

(3) Provides methods for individuals to prevent a licensee from disclosing that information.

B. Scope.

This regulation applies to:

(1) Nonpublic personal financial information about individuals who obtain or are claimants or beneficiaries of products or services primarily for personal, family or household purposes from licensees. This regulation does not apply to information about companies or about individuals who obtain products or services for business, commercial or agricultural purposes; and

(2) All nonpublic personal health information.

C. Compliance.

A licensee domiciled in this state that is in compliance with this regulation in a state that has not enacted laws or regulations that meet the requirements of Title V of the Gramm-Leach-Bliley Act (PL 102-106) may nonetheless be deemed to be in compliance with Title V of the Gramm-Leach-Bliley Act in such other state.

Section 3. Rule of Construction.
The examples in this regulation and the sample clauses in Appendix A, and the Federal Model Privacy Form in Appendix B of this regulation are not exclusive. Compliance with an example or use of a sample clause, to the extent applicable, constitutes compliance with this regulation.

Licensees may rely on use of the Federal Privacy Form in Appendix B, consistent with the attached instructions, as a safe harbor of compliance with the privacy notice content requirements of this regulation.

Section 4. Definitions.

As used in this regulation, unless the context requires otherwise:

A. "Affiliate" means any company that controls, is controlled by or is under common control with another company.

B.(1) "Clear and conspicuous" means that a notice is reasonably understandable and designed to call attention to the nature and significance of the information in the notice.

(2) Examples.

(a) Reasonably understandable. A licensee makes its notice reasonably understandable if it:

(i) Presents the information in the notice in clear, concise sentences, paragraphs, and sections:

(ii) Uses short explanatory sentences or bullet lists whenever possible;

(iii) Uses definite, concrete, everyday words and active voice whenever possible;

(iv) Avoids multiple negatives;

(v) Avoids legal and highly technical business terminology whenever possible; and

(vi) Avoids explanations that are imprecise and readily subject to different interpretations.

(b) Designed to call attention. A licensee designs its notice to call attention to the nature and significance of the information in it if the licensee:

(i) Uses a plain-language heading to call attention to the notice;

(ii) Uses a typeface and type size that are easy to read;

(iii) Provides wide margins and ample line spacing;

(iv) Uses boldface or italics for key words; and

(v) In a form that combines the licensee's notice with other information, uses distinctive type size, style, and graphic devices, such as shading or sidebars.

(c) Notices on web sites. If a licensee provides a notice on a web page, the licensee designs its notice to call attention to the nature and significance of the information in it if the licensee uses text or visual cues to encourage scrolling down the page if necessary to view the entire notice and ensure that other elements on the web site (such as text, graphics, hyperlinks or sound) do not distract attention from the notice, and the licensee either:

(i) Places the notice on a screen that consumers frequently access, such as a page on which transactions are conducted; or

(ii) Places a link on a screen that consumers frequently access, such as a page on which transactions are conducted, that connects directly to the notice and is labeled appropriately to convey the importance, nature and relevance of the notice.

C. "Collect" means to obtain information that the licensee organizes or can retrieve by the name of an individual or by identifying number, symbol or other identifying particular assigned to the individual, irrespective of the source of the underlying information.

D. "Company" means a corporation, limited liability company, business trust, general or limited partnership, association, sole proprietorship or similar organization.

E.(1) "Consumer" means an individual who seeks to obtain, obtains or has obtained an insurance product or service from a licensee that is to be used primarily for personal, family or household purposes, and about whom the licensee has nonpublic personal information, or that individual's legal representative.

(2) Examples.

(a) An individual who provides nonpublic personal information to a licensee in connection with obtaining or seeking to obtain financial, investment or economic advisory services relating to an insurance product or service is a consumer regardless of whether the licensee establishes an ongoing advisory relationship.

(b) An applicant for insurance prior to the inception of insurance coverage is a licensee's consumer.

(c) An individual who is a consumer of another financial institution is not a licensee's consumer solely because the licensee is acting as agent for, or provides processing or other services to, that financial institution.

(d) An individual is a licensee's consumer if:

(i)(I) The individual is a beneficiary of a life insurance policy underwritten by the licensee;

(II) The individual is a claimant under an insurance policy issued by the licensee;

(III) The individual is an insured or an annuitant under an insurance policy or an annuity, respectively, issued by the licensee; or

(IV) The individual is a mortgagor of a mortgage covered under a mortgage insurance policy; and

(ii) The licensee discloses nonpublic personal financial information about the individual to a nonaffiliated third party other than as permitted under Sections 15, 16, and 17 of this regulation.

(e) Provided that the licensee provides the initial, annual and revised notices under Section 10 of this regulation to the plan sponsor, group or blanket insurance policyholder or group annuity contract holder, or workers' compensation policyholder and further provided that the licensee does not disclose to a nonaffiliated third party nonpublic personal financial information about such an individual other than as permitted under Sections 15, 16, and 17 of this regulation, an individual is not the consumer of the licensee solely because he or she is:

(i) A participant or a beneficiary of an employee benefit plan that the licensee administers or sponsors or for which the licensee acts as a trustee, insurer or fiduciary;

(ii) Covered under a group or blanket insurance policy or group annuity contract issued by the licensee;

(iii) A claimant covered by a workers' compensation plan.

(f)(i) The individuals described in Subparagraph (e)(i) through (ii) of this Paragraph are consumers of a licensee if the licensee does not meet all the conditions of Subparagraph (e).

(ii) In no event shall the individuals, solely by virtue of the status described in Subparagraph (e)(i) through (ii) above, be deemed to be customers for purposes of this regulation.

(g) An individual is not a licensee's consumer solely because he or she is a beneficiary of a trust for which the licensee is a trustee.

(h) An individual is not a licensee's consumer solely because he or she has designated the licensee as trustee for a trust.

F. "Consumer reporting agency" has the same meaning as in Section 603(f) of the federal Fair Credit Reporting Act (15 U.S.C. 1681a(f)).

G. "Control" means:

(1) Ownership, control or power to vote twenty-five percent (25%) or more of the outstanding shares of any class of voting security of the company, directly or indirectly, or acting through one or more other persons;

(2) Control in any manner over the election of a majority of the directors, trustees or general partners (or individuals exercising similar functions) of the company; or

(3) The power to exercise, directly or indirectly, a controlling influence over the management or policies of the company, as the director determines.

H. "Customer" means a consumer who has a customer relationship with a licensee.

I. (1) "Customer relationship" means a continuing relationship between a consumer and a licensee under which the licensee provides one or more insurance products or services to the consumer that are to be used primarily for personal, family or household purposes.

(2) Examples.

(a) A consumer has a continuing relationship with a licensee if:

(i) The consumer is a current policyholder of an insurance product issued by or through the licensee; or

(ii) The consumer obtains financial, investment or economic advisory services relating to an insurance product or service from the licensee for a fee.

(b) A consumer does not have a continuing relationship with a licensee if:

(i) The consumer applies for insurance but does not purchase the insurance;

(ii) The licensee sells the consumer airline travel insurance in an isolated transaction;

(iii) The individual is no longer a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee;

(iv) The consumer is a beneficiary or claimant under a policy and has submitted a claim under a policy choosing a settlement option involving an ongoing relationship with the licensee;

(v) The consumer is a beneficiary or a claimant under a policy and has submitted a claim under that policy choosing a lump sum settlement option;

(vi) The customer's policy is lapsed, expired, or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve (12) consecutive months, other than annual privacy notices, material required by law or regulation, communication at the direction of a state or federal authority, or promotional materials;

(vii) The individual is an insured or an annuitant under an insurance policy or annuity, respectively, but is not the policyholder or owner of the insurance policy or annuity; or

(viii) For the purposes of this regulation, the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

J. "Director" means the director of the South Carolina Department of Insurance.

K.(1) "Financial institution" means any institution the business of which is engaging in activities that are financial in nature or incidental to such financial activities as described in Section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. 1843(k)).

(2) Financial institution does not include:

(i) Any person or entity with respect to any financial activity that is subject to the jurisdiction of the Commodity Futures Trading Commission under the Commodity Exchange Act (7 U.S.C. 1 et seq.);

(ii) The Federal Agricultural Mortgage Corporation or any entity charged and operating under the Farm Credit Act of 1971 (12 U.S.C. 2001 et seq.); or

(iii) Institutions chartered by Congress specifically to engage in securitizations, secondary market sales (including sales of servicing rights) or similar transactions related to a transaction of a consumer, as long as the institutions do not sell or transfer nonpublic personal information to a nonaffiliated third party.

L.(1) "Financial product or service" means any product or service that a financial holding company could offer by engaging in an activity that is financial in nature or incidental to such a financial activity under Section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. 1843(k)).

(2) Financial service includes a financial institution's evaluation or brokerage of information that the financial institution collects in connection with a request or an application from a consumer for a financial product or service.

M. "Health care" means:

(1) Preventive, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, services, procedures, tests or counseling that:

(a) Relates to the physical, mental or behavioral condition of an individual; or

(b) Affects the structure or function of the human body or any part of the human body, including the banking of blood, sperm, organs or any other tissue; or

(2) Prescribing, dispensing or furnishing to an individual drugs or biologicals, or medical devices or health care equipment and supplies.

N. "Health care provider" means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law, or a health care facility.

O. "Health information" means any information or data except age or gender, whether oral or recorded in any form or medium, created by or derived from a health care provider or the consumer that relates to:

(1) The past, present or future physical, mental or behavioral health or condition of an individual;

(2) The provision of health care to an individual; or

(3) Payment for the provision of health care to an individual.

P. (1) "Insurance product or service" means any product or service that is offered by a licensee pursuant to the insurance laws of this state.

(2) Insurance service includes a licensee's evaluation, brokerage or distribution of information that the licensee collects in connection with a request or an application from a consumer for a insurance product or service.

Q.(1) "Licensee" means all licensed insurers, producers and other persons licensed or required to be licensed, or authorized or required to be authorized, or registered or required to be registered pursuant to the Insurance Law of this state.

(2)(a) A licensee is not subject to the notice and opt out requirements for nonpublic personal financial information set forth in Articles I, II, III and IV of this regulation if the licensee is an employee, agent or other representative of another licensee ("the principal") and:

(b) The principal otherwise complies with, and provides the notices required by, the provisions of this regulation; and

(c) The licensee does not disclose any nonpublic personal information to any person other than the principal or its affiliates in a manner permitted by this regulation.

(3)(a) Subject to Subparagraph (b), "licensee" shall also include an unauthorized insurer that accepts business placed through a licensed excess lines broker in this state, but only in regard to the excess lines placements placed pursuant to S.C. Code Section 38-45-10 et. seq.

(b) An excess lines broker or excess lines insurer shall be deemed to be in compliance with the notice and opt out requirements for nonpublic personal financial information set forth in Articles I, II, III and IV of this regulation provided:

(i) The broker or insurer does not disclose nonpublic personal information of a consumer or a customer to nonaffiliated third parties for any purpose, including joint servicing or marketing under Section 15 of this regulation, except as permitted by Section 16 or 17 of this regulation; and

(ii) The broker or insurer delivers a notice to the consumer at the time a customer relationship is established on which the following is printed in 16-point type:

PRIVACY NOTICE

"NEITHER THE U.S. BROKERS THAT HANDLED THIS INSURANCE NOR THE INSURERS THAT HAVE UNDERWRITTEN THIS INSURANCE WILL DISCLOSE NONPUBLIC PERSONAL INFORMATION CONCERNING THE BUYER TO NONAFFILIATES OF THE BROKERS OR INSURERS EXCEPT AS PERMITTED BY LAW."

R.(1) "Nonaffiliated third party" means any person except:

(a) A licensee's affiliate; or

(b) A person employed jointly by a licensee and any company that is not the licensee's affiliate (but nonaffiliated third party includes the other company that jointly employs the person).

(2) Nonaffiliated third party includes any company that is an affiliate solely by virtue of the direct or indirect ownership or control of the company by the licensee or its affiliate in conducting merchant banking or investment banking activities of the type described in Section 4(k)(4)(H) or insurance company investment activities of the type described in Section 4(k)(4)(I) of the federal Bank Holding Company Act (12 U.S.C. 1843(k)(4)(H) and (I)).

S. "Nonpublic personal information" means nonpublic personal financial information and nonpublic personal health information.

T.(1) "Nonpublic personal financial information" means:

(a) Personally identifiable financial information; and

(b) Any list, description or other grouping of consumers (and publicly available information pertaining to them) that is derived using any personally identifiable financial information that is not publicly available.

(2) Nonpublic personal financial information does not include:

(a) Health information;

(b) Publicly available information, except as included on a list described in Subsection T(1)(b) of this section; or

(c) Any list, description or other grouping of consumers (and publicly available information pertaining to them) that is derived without using any personally identifiable financial information that is not publicly available.

(3) Examples of lists.

(a) Nonpublic personal financial information includes any list of individuals' names and street addresses that is derived in whole or in part using personally identifiable financial information that is not publicly available, such as account numbers.

(b) Nonpublic personal financial information does not include any list of individuals' names and addresses that contains only publicly available information, is not derived in whole or in part using personally identifiable financial information that is not publicly available, and is not disclosed in a manner that indicates that any of the individuals on the list is a consumer of a financial institution.

U. "Nonpublic personal health information" means health information:

(1) That identifies an individual who is the subject of the information; or

(2) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

V.(1) "Personally identifiable financial information" means any information:

(a) A consumer provides to a licensee to obtain an insurance product or service from the licensee;

(b) About a consumer resulting from a transaction involving an insurance product or service between a licensee and a consumer; or

(c) The licensee otherwise obtains about a consumer in connection with providing an insurance product or service to that consumer.

(2) Examples.

(a) Information included. Personally identifiable financial information includes:

(i) Information a consumer provides to a licensee on an application to obtain an insurance product or service;

(ii) Account balance information and payment history;

(iii) The fact that an individual is or has been one of the licensee's customers or has obtained an insurance product or service from the licensee;

(iv) Any information about the licensee's consumer if it is disclosed in a manner that indicates that the individual is or has been the licensee's consumer;

(v) Any information that a consumer provides to a licensee or that the licensee or its agent otherwise obtains in connection with collecting on a loan or servicing a loan;

(vi) Any information the licensee collects through an Internet cookie (an information-collecting device from a web server); and

(vii) Information from a consumer report.

(b) Information not included. Personally identifiable financial information does not include:

(i) Health information;

(ii) A list of names and addresses of customers of an entity that is not a financial institution; and

(iii) Information that does not identify a consumer, such as aggregate information or blind data that does not contain personal identifiers such as account numbers, names or addresses.

W.(1) "Publicly available information" means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from:

(a) Federal, state or local government records;

(b) Widely distributed media; or

(c) Disclosures to the general public that are required to be made by federal, state or local law.

(2) Reasonable basis. A licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine:

(a) That the information is of the type that is available to the general public; and

(b) Whether an individual can direct that the information not be made available to the general public and, if so, that the licensee's consumer has not done so.

(3) Examples.

(a) Government records. Publicly available information in government records includes information in government real estate records and security interest filings.

(b) Widely distributed media. Publicly available information from widely distributed media includes information from a telephone book, a television or radio program, a newspaper or a web site that is available to the general public on an unrestricted basis. A web site is not restricted merely because an Internet service provider or a site operator requires a fee or a password, so long as access is available to the general public.

(c) Reasonable basis.

(i) A licensee has a reasonable basis to believe that mortgage information is lawfully made available to the general public if the licensee has determined that the information is of the type included on the public record in the jurisdiction where the mortgage would be recorded.

(ii) A licensee has a reasonable basis to believe that an individual's telephone number is lawfully made available to the general public if the licensee has located the telephone number in the telephone book or the consumer has informed you that the telephone number is not unlisted.

ARTICLE II
PRIVACY AND OPT OUT NOTICES FOR FINANCIAL INFORMATION

Section 5. Initial Privacy Notice to Consumers Required.

A. Initial notice requirement. A licensee shall provide a clear and conspicuous notice that accurately reflects its privacy policies and practices to:

(1) Customer. An individual who becomes the licensee's customer, not later than when the licensee establishes a customer relationship, except as provided in Subsection E of this section; and

(2) Consumer. A consumer, before the licensee discloses any nonpublic personal financial information about the consumer to any nonaffiliated third party, if the licensee makes a disclosure other than as authorized by Sections 16 and 17.

B. When initial notice to a consumer is not required. A licensee is not required to provide an initial notice to a consumer under Subsection A(2) of this section if:

(1) The licensee does not disclose any nonpublic personal financial information about the consumer to any nonaffiliated third party, other than as authorized by Sections 16 and 17, and the licensee does not have a customer relationship with the consumer; or

(2) A notice has been provided by an affiliated licensee, as long as the notice clearly identifies all licensees to whom the notice applies and is accurate with respect to the licensee and the other institutions.

C. When the licensee establishes a customer relationship.

(1) General rule. A licensee establishes a customer relationship at the time the licensee and the consumer enter into a continuing relationship.

(2) Examples of establishing customer relationship. A licensee establishes a customer relationship when the consumer:

(a) Becomes a policyholder of a licensee that is an insurer when the insurer delivers an insurance policy or contract to the consumer, or in the case of a licensee that is an insurance producer or insurance broker, obtains insurance through that licensee; or

(b) Agrees to obtain financial, economic or investment advisory services relating to insurance products or services for a fee from the licensee.

D. Existing customers. When an existing customer obtains a new insurance product or service from a licensee that is to be used primarily for personal, family or household purposes, the licensee satisfies the initial notice requirements of Subsection A of this section as follows:

(1) The licensee may provide a revised policy notice, under Section 9, that covers the customer's new insurance product or service; or

(2) If the initial, revised or annual notice that the licensee most recently provided to that customer was accurate with respect to the new insurance product or service, the licensee does not need to provide a new privacy notice under Subsection A of this section.

E. Exceptions to allow subsequent delivery of notice.

(1) A licensee may provide the initial notice required by Subsection A(1) of this section within a reasonable time after the licensee establishes a customer relationship if:

(a) Establishing the customer relationship is not at the customer's election; or

(b) Providing notice not later than when the licensee establishes a customer relationship would substantially delay the customer's transaction and the customer agrees to receive the notice at a later time.

(2) Examples of exceptions.

(a) Not at customer's election. Establishing a customer relationship is not at the customer's election if a licensee acquires or is assigned a customer's policy from another financial institution or residual market mechanism and the customer does not have a choice about the licensee's acquisition or assignment.

(b) Substantial delay of customer's transaction. Providing notice not later than when a licensee establishes a customer relationship would substantially delay the customer's transaction when the licensee and the individual agree over the telephone to enter into a customer relationship involving prompt delivery of the insurance product or service.

(c) No substantial delay of customer's transaction. Providing notice not later than when a licensee establishes a customer relationship would not substantially delay the customer's transaction when the relationship is initiated in person at the licensee's office or through other means by which the customer may view the notice, such as on a web site.

F. Delivery. When a licensee is required to deliver an initial privacy notice by this section, the licensee shall deliver it according to Section 11. If the licensee uses a short-form initial notice for non-customers according to Section 7D, the licensee may deliver its privacy notice according to Section 7D(3).

Section 6. Annual Privacy Notice to Customers Required.

A.(1) General rule. A licensee shall provide a clear and conspicuous notice to customers that accurately reflects its privacy policies and practices not less than annually during the continuation of the customer relationship. Annually means at least once in any period of twelve (12) consecutive months during which that relationship exists. A licensee may define the twelve-consecutive-month period, but the licensee shall apply it to the customer on a consistent basis.

(2) Example. A licensee provides a notice annually if it defines the twelve-consecutive-month period as a calendar year and provides the annual notice to the customer once in each calendar year following the calendar year in which the licensee provided the initial notice. For example, if a customer opens an account on any day of year 1, the licensee shall provide an annual notice to that customer by December 31 of year 2.

B. Exception to general rule. A licensee that provides nonpublic personal information to nonaffiliated third parties only in accordance with Sections 15, 16, or 17 and has not changed its policies and practices with regard to disclosing nonpublic personal information from the policies and practices that were disclosed in the most recent disclosure sent to consumers in accordance with this section or Section 5 shall not be required to provide an annual disclosure under this section until such time as the licensee fails to comply with any criteria described in this paragraph.

C.(1) Termination of customer relationship. A licensee is not required to provide an annual notice to a former customer. A former customer is an individual with whom a licensee no longer has a continuing relationship.

(2) Examples.

(a) A licensee no longer has a continuing relationship with an individual if the individual no longer is a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee.

(b) A licensee no longer has a continuing relationship with an individual if the individual's policy is lapsed, expired or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve (12) consecutive months, other than to provide annual privacy notices, material required by law or regulation, or promotional materials.

(c) For the purposes of this regulation, a licensee no longer has a continuing relationship with an individual if the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

(d) A licensee no longer has a continuing relationship with a customer in the case of providing real estate settlement services, at the time the customer completes execution of all documents related to the real estate closing, payment for those services has been received, or the licensee has completed all of its responsibilities with respect to the settlement, including filing documents on the public record, whichever is later.

D. Delivery. When a licensee is required by this section to deliver an annual privacy notice, the licensee shall deliver it according to Section 11.

Section 7. Information to Be Included in Privacy Notices.

A. General rule. The initial, annual and revised privacy notices that a licensee provides under Sections 5, 6 and 9 shall include each of the following items of information, in addition to any other information the licensee wishes to provide, that applies to the licensee and to the consumers to whom the licensee sends its privacy notice:

(1) The categories of nonpublic personal financial information that the licensee collects;

(2) The categories of nonpublic personal financial information that the licensee discloses;

(3) The categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information, other than those parties to whom the licensee discloses information under Sections 16 and 17;

(4) The categories of nonpublic personal financial information about the licensee's former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information about the licensee's former customers, other than those parties to whom the licensee discloses information under Sections 16 and 17;

(5) If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under Section 15 (and no other exception in Sections 16 and 17 applies to that disclosure), a separate description of the categories of information the licensee discloses and the categories of third parties with whom the licensee has contracted;

(6) An explanation of the consumer's right under Section 12A to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise that right at that time;

(7) Any disclosures that the licensee makes under Section 603(d)(2)(A)(iii) of the federal Fair Credit Reporting Act (15 U.S.C. 1681a(d)(2)(A)(iii)) (that is, notices regarding the ability to opt out of disclosures of information among affiliates);

(8) The licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and

(9) Any disclosure that the licensee makes under Subsection B of this section.

B. Description of parties subject to exceptions. If a licensee discloses nonpublic personal financial information as authorized under Sections 16 and 17, the licensee is not required to list those exceptions in the initial or annual privacy notices required by Sections 5 and 6. When describing the categories of parties to whom disclosure is made, the licensee is required to state only that it makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

C. Examples.

(1) Categories of nonpublic personal financial information that the licensee collects. A licensee satisfies the requirement to categorize the nonpublic personal financial information it collects if the licensee categorizes it according to the source of the information, as applicable:

(a) Information from the consumer;

(b) Information about the consumer's transactions with the licensee or its affiliates;

(c) Information about the consumer's transactions with nonaffiliated third parties; and

(d) Information from a consumer reporting agency.

(2) Categories of nonpublic personal financial information a licensee discloses.

(a) A licensee satisfies the requirement to categorize nonpublic personal financial information it discloses if the licensee categorizes the information according to source, as described in Paragraph (1), as applicable, and provides a few examples to illustrate the types of information in each category. These might include:

(i) Information from the consumer, including application information, such as assets and income and identifying information, such as name, address and social security number;

(ii) Transaction information, such as information about balances, payment history and parties to the transaction; and

(iii) Information from consumer reports, such as a consumer's creditworthiness and credit history.

(b) A licensee does not adequately categorize the information that it discloses if the licensee uses only general terms, such as transaction information about the consumer.

(c) If a licensee reserves the right to disclose all of the nonpublic personal financial information about consumers that it collects, the licensee may simply state that fact without describing the categories or examples of nonpublic personal information that the licensee discloses.

(3) Categories of affiliates and nonaffiliated third parties to whom the licensee discloses.

(a) A licensee satisfies the requirement to categorize the affiliates and nonaffiliated third parties to which the licensee discloses nonpublic personal financial information about consumers if the licensee identifies the types of businesses in which they engage.

(b) Types of businesses may be described by general terms only if the licensee uses a few illustrative examples of significant lines of business. For example, a licensee may use the term financial products or services if it includes appropriate examples of significant lines of businesses, such as life insurer, automobile insurer, consumer banking or securities brokerage.

(c) A licensee also may categorize the affiliates and nonaffiliated third parties to which it discloses nonpublic personal financial information about consumers using more detailed categories.

(4) Disclosures under exception for service providers and joint marketers. If a licensee discloses nonpublic personal financial information under the exception in Section 15 to a nonaffiliated third party to market products or services that it offers alone or jointly with another financial institution, the licensee satisfies the disclosure requirement of Subsection A(5) of this section if it:

(a) Lists the categories of nonpublic personal financial information it discloses, using the same categories and examples the licensee used to meet the requirements of Subsection A(2) of this section, as applicable; and

(b) States whether the third party is:

(i) A service provider that performs marketing services on the licensee's behalf or on behalf of the licensee and another financial institution; or

(ii) A financial institution with whom the licensee has a joint marketing agreement.

(5) Simplified notices. If a licensee does not disclose, and does not wish to reserve the right to disclose, nonpublic personal financial information about customers or former customers to affiliates or nonaffiliated third parties except as authorized under Sections 16 and 17 the licensee may simply state that fact, in addition to the information it shall provide under Subsections A(1), A(8), A(9), and Subsection B of this section.

(6) Confidentiality and security. A licensee describes its policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information if it does both of the following:

(a) Describes in general terms who is authorized to have access to the information; and

(b) States whether the licensee has security practices and procedures in place to ensure the confidentiality of the information in accordance with the licensee's policy. The licensee is not required to describe technical information about the safeguards it uses.

D. Short-form initial notice with opt out notice for non-customers.

(1) A licensee may satisfy the initial notice requirements in Sections 5A(2) and 8C for a consumer who is not a customer by providing a short-form initial notice at the same time as the licensee delivers an opt out notice as required in Section 8.

(2) A short-form initial notice shall:

(a) Be clear and conspicuous;

(b) State that the licensee's privacy notice is available upon request; and

(c) Explain a reasonable means by which the consumer may obtain that notice.

(3) The licensee shall deliver its short-form initial notice according to Section 11. The licensee is not required to deliver its privacy notice with its short-form initial notice. The licensee instead may simply provide the consumer a reasonable means to obtain its privacy notice. If a consumer who receives the licensee's short-form notice requests the licensee's privacy notice, the licensee shall deliver its privacy notice according to Section 11.

(4) Examples of obtaining privacy notice. The licensee provides a reasonable means by which a consumer may obtain a copy of its privacy notice if the licensee:

(a) Provides a toll-free telephone number that the consumer may call to request the notice; or

(b) For a consumer who conducts business in person at the licensee's office, maintains copies of the notice on hand that the licensee provides to the consumer immediately upon request.

E. Future disclosures. The licensee's notice may include:

(1) Categories of nonpublic personal financial information that the licensee reserves the right to disclose in the future, but does not currently disclose; and

(2) Categories of affiliates or nonaffiliated third parties to whom the licensee reserves the right in the future to disclose, but to whom the licensee does not currently disclose, nonpublic personal financial information.

F. Sample clauses and Federal Model Privacy Form. Sample clauses illustrating some of the notice content required by this section and the Federal Model Privacy Form are included in Appendix A and Appendix B of this regulation.

Section 8. Form of Opt Out Notice to Consumers and Opt Out Methods.

A.(1) Form of opt out notice. If a licensee is required to provide an opt out notice under Section 12A, it shall provide a clear and conspicuous notice to each of its consumers that accurately explains the right to opt out under that section. The notice shall state:

(a) That the licensee discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party;

(b) That the consumer has the right to opt out of that disclosure; and

(c) A reasonable means by which the consumer may exercise the opt out right.

(2) Examples.

(a) Adequate opt out notice. A licensee provides adequate notice that the consumer can opt out of the disclosure of nonpublic personal financial information to a nonaffiliated third party if the licensee:

(i) Identifies all of the categories of nonpublic personal financial information that it discloses or reserves the right to disclose, and all of the categories of nonaffiliated third parties to which the licensee discloses the information, as described in Section 7A(2) and (3), and states that the consumer can opt out of the disclosure of that information; and

(ii) Identifies the insurance products or services that the consumer obtains from the licensee, either singly or jointly, to which the opt out direction would apply.

(b) Reasonable opt out means. A licensee provides a reasonable means to exercise an opt out right if it:

(i) Designates check-off boxes in a prominent position on the relevant forms with the opt out notice;

(ii) Includes a reply form together with the opt out notice;

(iii) Provides an electronic means to opt out, such as a form that can be sent via electronic mail or a process at the licensee's web site, if the consumer agrees to the electronic delivery of information; or

(iv) Provides a toll-free telephone number that consumers may call to opt out.

(c) Unreasonable opt out means. A licensee does not provide a reasonable means of opting out if:

(i) The only means of opting out is for the consumer to write his or her own letter to exercise that opt out right; or

(ii) The only means of opting out as described in any notice subsequent to the initial notice is to use a check-off box that the licensee provided with the initial notice but did not include with the subsequent notice.

(d) Specific opt out means. A licensee may require each consumer to opt out through a specific means, as long as that means is reasonable for that consumer.

B. Same form as initial notice permitted. A licensee may provide the opt out notice together with or on the same written or electronic form as the initial notice the licensee provides in accordance with Section 5.

C. Initial notice required when opt out notice delivered subsequent to initial notice. If a licensee provides the opt out notice later than required for the initial notice in accordance with Section 5, the licensee shall also include a copy of the initial notice with the opt out notice in writing or, if the consumer agrees, electronically.

D. Joint relationships.

(1) If two (2) or more consumers jointly obtain an insurance product or service from a licensee, the licensee may provide a single opt out notice. The licensee's opt out notice shall explain how the licensee will treat an opt out direction by a joint consumer (as explained in Paragraph (5) of this subsection).

(2) Any of the joint consumers may exercise the right to opt out. The licensee may either:

(a) Treat an opt out direction by a joint consumer as applying to all of the associated joint consumers; or

(b) Permit each joint consumer to opt out separately.

(3) If a licensee permits each joint consumer to opt out separately, the licensee shall permit one of the joint consumers to opt out on behalf of all of the joint consumers.

(4) A licensee may not require all joint consumers to opt out before it implements any opt out direction.

(5) Example. If John and Mary are both named policyholders on a homeowner's insurance policy issued by a licensee and the licensee sends policy statements to John's address, the licensee may do any of the following, but it shall explain in its opt out notice which opt out policy the licensee will follow:

(a) Send a single opt out notice to John's address, but the licensee shall accept an opt out direction from either John or Mary.

(b) Treat an opt out direction by either John or Mary as applying to the entire policy. If the licensee does so and John opts out, the licensee may not require Mary to opt out as well before implementing John's opt out direction.

(c) Permit John and Mary to make different opt out directions. If the licensee does so:

(i) It shall permit John and Mary to opt out for each other;

(ii) If both opt out, the licensee shall permit both of them to notify it in a single response (such as on a form or through a telephone call); and

(iii) If John opts out and Mary does not, the licensee may only disclose nonpublic personal financial information about Mary, but not about John and not about John and Mary jointly.

E. Time to comply with opt out. A licensee shall comply with a consumer's opt out direction as soon as reasonably practicable after the licensee receives it.

F. Continuing right to opt out. A consumer may exercise the right to opt out at any time.

G. Duration of consumer's opt out direction.

(1) A consumer's direction to opt out under this section is effective until the consumer revokes it in writing or, if the consumer agrees, electronically.

(2) When a customer relationship terminates, the customer's opt out direction continues to apply to the nonpublic personal financial information that the licensee collected during or related to that relationship. If the individual subsequently establishes a new customer relationship with the licensee, the opt out direction that applied to the former relationship does not apply to the new relationship.

H. Delivery. When a licensee is required to deliver an opt out notice by this section, the licensee shall deliver it according to Section 11.

Section 9. Revised Privacy Notices.

A. General rule. Except as otherwise authorized in this regulation, a licensee shall not, directly or through an affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party other than as described in the initial notice that the licensee provided to that consumer under Section 5, unless:

(1) The licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices;

(2) The licensee has provided to the consumer a new opt out notice;

(3) The licensee has given the consumer a reasonable opportunity, before the licensee discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

(4) The consumer does not opt out.

B. Examples.

(1) Except as otherwise permitted by Sections 15, 16, and 17, a licensee shall provide a revised notice before it:

(a) Discloses a new category of nonpublic personal financial information to any nonaffiliated third party;

(b) Discloses nonpublic personal financial information to a new category of nonaffiliated third party; or

(c) Discloses nonpublic personal financial information about a former customer to a nonaffiliated third party, if that former customer has not had the opportunity to exercise an opt out right regarding that disclosure.

(2) A revised notice is not required if the licensee discloses nonpublic personal financial information to a new nonaffiliated third party that the licensee adequately described in its prior notice.

C. Delivery. When a licensee is required to deliver a revised privacy notice by this section, the licensee shall deliver it according to Section 11.

Section 10. Privacy Notices to Group Policyholders

Unless a licensee is providing privacy notices directly to covered individuals described in Section 4E(2)(e)(i), (ii), or (iii), a licensee shall provide initial, annual and revised notices to the plan sponsor, group or blanket insurance policyholder or group annuity contract holder or workers' compensation policyholder, in the manner described in Sections 5 through 9 of this regulation, describing the licensee's privacy practices with respect to nonpublic personal information about individuals covered under the policies, contracts or plans.

Section 11. Delivery.

A. How to provide notices. A licensee shall provide any notices that this regulation requires so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically.

B.(1) Examples of reasonable expectation of actual notice. A licensee may reasonably expect that a consumer will receive actual notice if the licensee:

(a) Hand-delivers a printed copy of the notice to the consumer;

(b) Mails a printed copy of the notice to the last known address of the consumer separately, or in a policy, billing or other written communication;

(c) For a consumer who conducts transactions electronically, posts the notice on the electronic site and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining a particular insurance product or service;

(d) For an isolated transaction with a consumer, such as the licensee providing an insurance quote or selling the consumer travel insurance, posts the notice and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining the particular insurance product or service.

(2) Examples of unreasonable expectation of actual notice. A licensee may not, however, reasonably expect that a consumer will receive actual notice of its privacy policies and practices if it:

(a) Only posts a sign in its office or generally publishes advertisements of its privacy policies and practices; or

(b) Sends the notice via electronic mail to a consumer who does not obtain an insurance product or service from the licensee electronically.

C. Annual notices only. A licensee may reasonably expect that a customer will receive actual notice of the licensee's annual privacy notice if:

(1) The customer uses the licensee's web site to access insurance products and services electronically and agrees to receive notices at the web site and the licensee posts its current privacy notice continuously in a clear and conspicuous manner on the web site; or

(2) The customer has requested that the licensee refrain from sending any information regarding the customer relationship, and the licensee's current privacy notice remains available to the customer upon request.

D. Oral description of notice insufficient. A licensee may not provide any notice required by this regulation solely by orally explaining the notice, either in person or over the telephone.

E. Retention or accessibility of notices for customers.

(1) For customers only, a licensee shall provide the initial notice required by Section 5A(1), the annual notice required by Section 6A, and the revised notice required by Section 9 so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically.

(2) Examples of retention or accessibility. A licensee provides a privacy notice to the customer so that the customer can retain it or obtain it later if the licensee:

(a) Hand-delivers a printed copy of the notice to the customer;

(b) Mails a printed copy of the notice to the last known address of the customer; or

(c) Makes its current privacy notice available on a web site (or a link to another web site) for the customer who obtains an insurance product or service electronically and agrees to receive the notice at the web site.

F. Joint notice with other financial institutions. A licensee may provide a joint notice from the licensee and one or more of its affiliates or other financial institutions, as identified in the notice, as long as the notice is accurate with respect to the licensee and the other institutions. A licensee also may provide a notice on behalf of another financial institution.

G. Joint relationships. If two (2) or more consumers jointly obtain an insurance product or service from a licensee, the licensee may satisfy the initial, annual and revised notice requirements of Sections 5A, 6A and 9A, respectively, by providing one notice to those consumers jointly.

ARTICLE III
LIMITS ON DISCLOSURES OF FINANCIAL INFORMATION

Section 12. Limits on Disclosure of Nonpublic Personal Financial Information to Nonaffiliated Third Parties.

A.(1) Conditions for disclosure. Except as otherwise authorized in this regulation, a licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party unless:

(a) The licensee has provided to the consumer an initial notice as required under Section 5;

(b) The licensee has provided to the consumer an opt out notice as required in Section 8;

(c) The licensee has given the consumer a reasonable opportunity, before it discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

(d) The consumer does not opt out.

(2) Opt out definition. Opt out means a direction by the consumer that the licensee not disclose nonpublic personal financial information about that consumer to a nonaffiliated third party, other than as permitted by Sections 15, 16 and 17.

(3) Examples of reasonable opportunity to opt out. A licensee provides a consumer with a reasonable opportunity to opt out if:

(a) By mail. The licensee mails the notices required in Paragraph (1) of this subsection to the consumer and allows the consumer to opt out by mailing a form, calling a toll-free telephone number or any other reasonable means within thirty (30) days from the date the licensee mailed the notices.

(b) By electronic means. A customer opens an on-line account with a licensee and agrees to receive the notices required in Paragraph (1) of this subsection electronically, and the licensee allows the customer to opt out by any reasonable means within thirty (30) days after the date that the customer acknowledges receipt of the notices in conjunction with opening the account.

(c) Isolated transaction with consumer. For an isolated transaction such as providing the consumer with an insurance quote, a licensee provides the consumer with a reasonable opportunity to opt out if the licensee provides the notices required in Paragraph (1) of this subsection at the time of the transaction and requests that the consumer decide, as a necessary part of the transaction, whether to opt out before completing the transaction.

B. Application of opt out to all consumers and all nonpublic personal financial information.

(1) A licensee shall comply with this section, regardless of whether the licensee and the consumer have established a customer relationship.

(2) Unless a licensee complies with this section, the licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer that the licensee has collected, regardless of whether the licensee collected it before or after receiving the direction to opt out from the consumer.

C. Partial opt out. A licensee may allow a consumer to select certain nonpublic personal financial information or certain nonaffiliated third parties with respect to which the consumer wishes to opt out.

Section 13. Limits on Re-disclosure and Reuse of Nonpublic Personal Financial Information.

A.(1) Information the licensee receives under an exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution under an exception in Sections 16 or 17 of this regulation, the licensee's disclosure and use of that information is limited as follows:

(a) The licensee may disclose the information to the affiliates of the financial institution from which the licensee received the information;

(b) The licensee may disclose the information to its affiliates, but the licensee's affiliates may, in turn, disclose and use the information only to the extent that the licensee may disclose and use the information; and

(c) The licensee may disclose and use the information pursuant to an exception in Sections 16 or 17 of this regulation, in the ordinary course of business to carry out the activity covered by the exception under which the licensee received the information.

(2) Example. If a licensee receives information from a nonaffiliated financial institution for claims settlement purposes, the licensee may disclose the information for fraud prevention, or in response to a properly authorized subpoena. The licensee may not disclose that information to a third party for marketing purposes or use that information for its own marketing purposes.

B.(1) Information a licensee receives outside of an exception. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution other than under an exception in Sections 16 or 17 of this regulation, the licensee may disclose the information only:

(a) To the affiliates of the financial institution from which the licensee received the information;

(b) To its affiliates, but its affiliates may, in turn, disclose the information only to the extent that the licensee may disclose the information; and

(c) To any other person, if the disclosure would be lawful if made directly to that person by the financial institution from which the licensee received the information.

(2) Example. If a licensee obtains a customer list from a nonaffiliated financial institution outside of the exceptions in Sections 16 or 17:

(a) The licensee may use that list for its own purposes; and

(b) The licensee may disclose that list to another nonaffiliated third party only if the financial institution from which the licensee purchased the list could have lawfully disclosed the list to that third party. That is, the licensee may disclose the list in accordance with the privacy policy of the financial institution from which the licensee received the list, as limited by the opt out direction of each consumer whose nonpublic personal financial information the licensee intends to disclose, and the licensee may disclose the list in accordance with an exception in Sections 16 or 17, such as to the licensee's attorneys or accountants.

C. Information a licensee discloses under an exception. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under an exception in Sections 16 or 17 of this regulation, the third party may disclose and use that information only as follows:

(1) The third party may disclose the information to the licensee's affiliates;

(2) The third party may disclose the information to its affiliates, but its affiliates may, in turn, disclose and use the information only to the extent that the third party may disclose and use the information; and

(3) The third party may disclose and use the information pursuant to an exception in Sections 16 or 17 in the ordinary course of business to carry out the activity covered by the exception under which it received the information.

D. Information a licensee discloses outside of an exception. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party other than under an exception in Sections 16 or 17 of this regulation, the third party may disclose the information only:

(1) To the licensee's affiliates;

(2) To the third party's affiliates, but the third party's affiliates, in turn, may disclose the information only to the extent the third party can disclose the information; and

(3) To any other person, if the disclosure would be lawful if the licensee made it directly to that person.

Section 14. Limits on Sharing Account Number Information for Marketing Purposes.

A. General prohibition on disclosure of account numbers. A licensee shall not, directly or through an affiliate, disclose, other than to a consumer reporting agency, a policy number or similar form of access number or access code for a consumer's policy or transaction account to any nonaffiliated third party for use in telemarketing, direct mail marketing or other marketing through electronic mail to the consumer.

B. Exceptions. Subsection A of this section does not apply if a licensee discloses a policy number or similar form of access number or access code:

(1) To the licensee's service provider solely in order to perform marketing for the licensee 's own products or services, as long as the service provider is not authorized to directly initiate charges to the account;

(2) To a licensee who is a producer solely in order to perform marketing for the licensee's own products or services; or

(3) To a participant in an affinity or similar program where the participants in the program are identified to the customer when the customer enters into the program.

C. Examples.

(1) Policy number. A policy number, or similar form of access number or access code, does not include a number or code in an encrypted form, as long as the licensee does not provide the recipient with a means to decode the number or code.

(2) Policy or transaction account. For the purposes of this section, a policy or transaction account is an account other than a deposit account or a credit card account. A policy or transaction account does not include an account to which third parties cannot initiate charges.

ARTICLE IV
EXCEPTIONS TO LIMITS ON DISCLOSURES OF FINANCIAL INFORMATION

Section 15. Exception to Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information for Service Providers and Joint Marketing.

A. General rule.

(1) The opt out requirements in Sections 8 and 12 do not apply when a licensee provides nonpublic personal financial information to a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf, if the licensee:

(a) Provides the initial notice in accordance with Section 5; and

(b) Enters into a contractual agreement with the third party that prohibits the third party from disclosing or using the information other than to carry out the purposes for which the licensee disclosed the information, including use under an exception in Sections 16 or 17 in the ordinary course of business to carry out those purposes.

(2) Example. If a licensee discloses nonpublic personal financial information under this section to a financial institution with which the licensee performs joint marketing, the licensee's contractual agreement with that institution meets the requirements of Paragraph (1)(b) of this subsection if it prohibits the institution from disclosing or using the nonpublic personal financial information except as necessary to carry out the joint marketing or under an exception in Sections 16 or 17 in the ordinary course of business to carry out that joint marketing.

B. Service may include joint marketing. The services a nonaffiliated third party performs for a licensee under Subsection A of this section may include marketing of the licensee's own products or services or marketing of financial products or services offered pursuant to joint agreements between the licensee and one or more financial institutions.

C. Definition of "joint agreement." For purposes of this section, "joint agreement" means a written contract pursuant to which a licensee and one or more financial institutions jointly offer, endorse or sponsor a financial product or service.

Section 16. Exceptions to Notice and Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information for Processing and Servicing Transactions.

A. Exceptions for processing transactions at consumer's request. The requirements for initial notice in Section 5A(2), the opt out in Sections 8 and 12, and service providers and joint marketing in Section 15 do not apply if the licensee discloses nonpublic personal financial information as necessary to effect, administer or enforce a transaction that a consumer requests or authorizes, or in connection with:

(1) Servicing or processing an insurance product or service that a consumer requests or authorizes;

(2) Maintaining or servicing the consumer's account with a licensee, or with another entity as part of a private label credit card program or other extension of credit on behalf of such entity;

(3) A proposed or actual securitization, secondary market sale (including sales of servicing rights) or similar transaction related to a transaction of the consumer; or

(4) Reinsurance or stop loss or excess loss insurance.

B. "Necessary to effect, administer or enforce a transaction" means that the disclosure is:

(1) Required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out the financial transaction or providing the product or service; or

(2) Required, or is a usual, appropriate or acceptable method:

(a) To carry out the transaction or the product or service business of which the transaction is a part, and record, service or maintain the consumer's account in the ordinary course of providing the insurance product or service;

(b) To administer or service benefits or claims relating to the transaction or the product or service business of which it is a part;

(c) To provide a confirmation, statement or other record of the transaction, or information on the status or value of the insurance product or service to the consumer or the consumer's agent or broker;

(d) To accrue or recognize incentives or bonuses associated with the transaction that are provided by a licensee or any other party;

(e) To underwrite insurance at the consumer's request or for any of the following purposes as they relate to a consumer's insurance: account administration, reporting, investigating or preventing fraud or material misrepresentation, processing premium payments, processing insurance claims, administering insurance benefits (including utilization review activities), participating in research projects or as otherwise required or specifically permitted by federal or state law; or

(f) In connection with:

(i) The authorization, settlement, billing, processing, clearing, transferring, reconciling or collection of amounts charged, debited or otherwise paid using a debit, credit or other payment card, check or account number, or by other payment means;

(ii) The transfer of receivables, accounts or interests therein; or

(iii) The audit of debit, credit or other payment information.

Section 17. Other Exceptions to Notice and Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information.

A. Exceptions to opt out requirements. The requirements for initial notice to consumers in Section 5A(2), the opt out in Sections 8 and 12, and service providers and joint marketing in Section 15 do not apply when a licensee discloses nonpublic personal financial information:

(1) With the consent or at the direction of the consumer, provided that the consumer has not revoked the consent or direction;

(2)(a) To protect the confidentiality or security of a licensee's records pertaining to the consumer, service, product or transaction;

(b) To protect against or prevent actual or potential fraud or unauthorized transactions;

(c) For required institutional risk control or for resolving consumer disputes or inquiries;

(d) To persons holding a legal or beneficial interest relating to the consumer; or

(e) To persons acting in a fiduciary or representative capacity on behalf of the consumer;

(3) To provide information to insurance rate advisory organizations, guaranty funds or agencies, agencies that are rating a licensee, persons that are assessing the licensee's compliance with industry standards, and the licensee's attorneys, accountants and auditors;

(4) To the extent specifically permitted or required under other provisions of law and in accordance with the federal Right to Financial Privacy Act of 1978 (12 U.S.C. 3401 et seq.), to law enforcement agencies (including the Federal Reserve Board, Office of the Comptroller of the Currency, Federal Deposit Insurance Corporation, Office of Thrift Supervision, National Credit Union Administration, the Securities and Exchange Commission, the Secretary of the Treasury, with respect to 31 U.S.C. Chapter 53, Subchapter II (Records and Reports on Monetary Instruments and Transactions) and 12 U.S.C. Chapter 21 (Financial Record keeping), a state insurance authority, and the Federal Trade Commission), self-regulatory organizations or for an investigation on a matter related to public safety;

(5)(a) To a consumer reporting agency in accordance with the federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.); or

(b) From a consumer report reported by a consumer reporting agency;

(6) In connection with a proposed or actual sale, merger, transfer or exchange of all or a portion of a business or operating unit if the disclosure of nonpublic personal financial information concerns solely consumers of the business or unit;

(7)(a) To comply with federal, state or local laws, rules and other applicable legal requirements;

(b) To comply with a properly authorized civil, criminal or regulatory investigation, or subpoena or summons by federal, state or local authorities;

(c) To respond to judicial process or government regulatory authorities having jurisdiction over a licensee for examination, compliance or other purposes as authorized by law; or

(8) For purposes related to the replacement of a group benefit plan, a group health plan, a group welfare plan or a workers' compensation plan.

B. Example of revocation of consent. A consumer may revoke consent by subsequently exercising the right to opt out of future disclosures of nonpublic personal information as permitted under Section 8F.

ARTICLE V
RULES FOR HEALTH INFORMATION

Section 18. When Authorization Required for Disclosure of Nonpublic Personal Health Information.

A. A licensee shall not disclose nonpublic personal health information about a consumer or customer unless an authorization is obtained from the consumer or customer whose nonpublic personal health information is sought to be disclosed.

B. Nothing in this section shall prohibit, restrict or require an authorization for the disclosure of nonpublic personal health information by a licensee for the performance of the following insurance functions by or on behalf of the licensee: claims administration; claims adjustment and management; detection, investigation or reporting of actual or potential fraud, misrepresentation or criminal activity; underwriting; policy placement or issuance; loss control; ratemaking and guaranty fund functions; reinsurance and excess loss insurance; risk management; case management; disease management; quality assurance; quality improvement; performance evaluation; provider credentialing verification; utilization review; peer review activities; actuarial, scientific, medical or public policy research; grievance procedures; internal administration of compliance, managerial, and information systems; policyholder service functions; auditing; reporting; database security; administration of consumer disputes and inquiries; external accreditation standards; the replacement of a group benefit plan or workers compensation policy or program; activities in connection with a sale, merger, transfer or exchange of all or part of a business or operating unit; any activity that permits disclosure without authorization pursuant to the federal Health Insurance Portability and Accountability Act privacy rules promulgated by the U.S. Department of Health and Human Services; disclosure that is required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out a transaction or providing a product or service that a consumer requests or authorizes; and any activity otherwise permitted by law, required pursuant to governmental reporting authority, or to comply with legal process. Additional insurance functions may be added with the approval of the Director to the extent they are necessary for appropriate performance of insurance functions and are fair and reasonable to the interest of consumers.

Section 19. Authorizations.

A. A valid authorization to disclose nonpublic personal health information pursuant to this Article V shall be in written or electronic form and shall contain all of the following:

(1) The identity of the consumer or customer who is the subject of the nonpublic personal health information;

(2) A general description of the types of nonpublic personal health information to be disclosed;

(3) General descriptions of the parties to whom the licensee discloses nonpublic personal health information, the purpose of the disclosure and how the information will be used;

(4) The signature of the consumer or customer who is the subject of the nonpublic personal health information or the individual who is legally empowered to grant authority and the date signed; and

(5) Notice of the length of time for which the authorization is valid and that the consumer or customer may revoke the authorization at any time and the procedure for making a revocation.

B. An authorization for the purposes of this Article V shall specify a length of time for which the authorization shall remain valid, which in no event shall be for more than twenty-four (24) months.

C. A consumer or customer who is the subject of nonpublic personal health information may revoke an authorization provided pursuant to this Article V at any time, subject to the rights of an individual who acted in reliance on the authorization prior to notice of the revocation.

D. A licensee shall retain the authorization or revocation or a copy thereof in the record of the individual who is the subject of nonpublic personal health information.

Section 20. Authorization Request Delivery.

A request for authorization and an authorization form may be delivered to a consumer or a customer as part of an opt-out notice pursuant to Section 11, provided that the request and the authorization form are clear and

conspicuous. An authorization form is not required to be delivered to the consumer or customer or included in any other notices unless the licensee intends to disclose protected health information and nonpublic personal health information pursuant to Section 18A.

Section 21. Relationship to Federal Rules.
Irrespective of whether a licensee is subject to the federal Health Insurance Portability and Accountability Act privacy rule as promulgated by the U.S. Department of Health and Human Services 45 CFR Part 160 (the "federal rule"), if a licensee complies with all requirements of the federal rule except for its effective date provision, the licensee shall not be subject to the provisions of this Article V.

Section 22. Relationship to State Laws.
Nothing in this article shall preempt or supersede existing state law related to medical records, health or insurance information privacy.

ARTICLE VI
ADDITIONAL PROVISIONS

Section 23. Protection of Fair Credit Reporting Act.
Nothing in this regulation shall be construed to modify, limit or supersede the operation of the federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.), and no inference shall be drawn on the basis of the provisions of this regulation regarding whether information is transaction or experience information under Section 603 of that Act.

Section 24. Nondiscrimination

A. A licensee shall not unfairly discriminate against any consumer or customer because that consumer or customer has opted out from the disclosure of his or her nonpublic personal financial information pursuant to the provisions of this regulation.

B. A licensee shall not unfairly discriminate against a consumer or customer because that consumer or customer has not granted authorization for the disclosure of his or her nonpublic personal health information pursuant to the provisions of this regulation.

Section 25. Violation.
Persons violating the provisions of this regulation shall have committed an unfair trade practice and shall be subject to the penalties set forth in Chapter 57 of Title 38 of the South Carolina Code of Laws.

Section 26. Severability.
If any section or portion of a section of this regulation or its applicability to any person or circumstance is held invalid by a court of competent jurisdiction, the remainder of the regulation or the applicability of the provision to other persons or circumstances shall not be affected.

Section 27. Effective Date.

A. Effective date. This regulation is effective upon publication of the final regulation in the State Register.

APPENDIX A
SAMPLE CLAUSES

Appendix

A-1. Categories of information a licensee collects (all institutions).
A-2. Categories of information a licensee discloses (institutions that disclose outside of the exceptions).
A-3. Categories of information a licensee discloses and parties to whom the licensee discloses (institutions that do not disclose outside of the exceptions).
A-4. Categories of parties to whom a licensee discloses (institutions that disclose outside of the exceptions).
A-5. Service provider/ joint marketing exception
A-6. Explanation of opt out right (institutions that disclose outside of the exceptions).

A-7. Confidentiality and security (all institutions).

Licensees, including a group of financial holding company affiliates that use a common privacy notice, may use the following sample clauses, if the clause is accurate for each institution that uses the notice. (Note that disclosure of certain information, such as assets, income and information from a consumer reporting agency, may give rise to obligations under the federal Fair Credit Reporting Act, such as a requirement to permit a consumer to opt out of disclosures to affiliates or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.

A-1. Categories of information a licensee collects (all institutions).
A licensee may use this clause, as applicable, to meet the requirement of Section 7A(1) to describe the categories of nonpublic personal information the licensee collects.
Sample Clause A-1:
We collect nonpublic personal information about you from the following sources:
• Information we receive from you on applications or other forms;
• Information about your transactions with us, our affiliates or others; and
• Information we receive from a consumer reporting agency.

A-2. Categories of information a licensee discloses (institutions that disclose outside of the exceptions).
A licensee may use one of these clauses, as applicable, to meet the requirement of Section 7A(2) to describe the categories of nonpublic personal information the licensee discloses. The licensee may use these clauses if it discloses nonpublic personal information other than as permitted by the exceptions in Sections 15, 16 and 17.
Sample Clause A-2, Alternative 1:
We may disclose the following kinds of nonpublic personal information about you:
• Information we receive from you on applications or other forms, such as [provide illustrative examples, such as "your name, address, social security number, assets, income, and beneficiaries"];
• Information about your transactions with us, our affiliates or others, such as [provide illustrative examples, such as "your policy coverage, premiums, and payment history"]; and
• Information we receive from a consumer reporting agency, such as [provide illustrative examples, such as "your creditworthiness and credit history"].
Sample Clause A-2, Alternative 2:
We may disclose all of the information that we collect, as described [describe location in the notice, such as "above" or "below"].

A-3. Categories of information a licensee discloses and parties to whom the licensee discloses (institutions that do not disclose outside of the exceptions).
A licensee may use this clause, as applicable, to meet the requirements of Sections 7A(2), (3), and (4) to describe the categories of nonpublic personal information about customers and former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses. A licensee may use this clause if the licensee does not disclose nonpublic personal information to any party, other than as permitted by the exceptions in Sections 16 and 17.
Sample Clause A-3:
We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law.

A-4. Categories of parties to whom a licensee discloses (institutions that disclose outside of the exceptions).
A licensee may use this clause, as applicable, to meet the requirement of Section 7A(3) to describe the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal information. This clause may be used if the licensee discloses nonpublic personal information other than as permitted by the exceptions in Sections 15, 16 and 17, as well as when permitted by the exceptions in Sections 16 and 17.
Sample Clause A-4:
We may disclose nonpublic personal information about you to the following types of third parties:

• Financial service providers, such as [provide illustrative examples, such as "life insurers, automobile insurers, mortgage bankers, securities broker-dealers, and insurance agents"];
• Non-financial companies, such as [provide illustrative examples, such as "retailers, direct marketers, airlines, and publishers"]; and
• Others, such as [provide illustrative examples, such as "non-profit organizations"].
We may also disclose nonpublic personal information about you to nonaffiliated third parties as permitted by law.

A-5. Service provider/joint marketing exception.

A licensee may use one of these clauses, as applicable, to meet the requirements of Section 7A(5) related to the exception for service providers and joint marketers in Section ~~14~~15. If a licensee discloses nonpublic personal information under this exception, the licensee shall describe the categories of nonpublic personal information the licensee discloses and the categories of third parties with which the licensee has contracted.
Sample Clause A-5, Alternative 1:
We may disclose the following information to companies that perform marketing services on our behalf or to other financial institutions with which we have joint marketing agreements:
• Information we receive from you on applications or other forms, such as [provide illustrative examples, such as "your name, address, social security number, assets, income, and beneficiaries"];
• Information about your transactions with us, our affiliates or others, such as [provide illustrative examples, such as "your policy coverage, premium, and payment history"]; and
• Information we receive from a consumer reporting agency, such as [provide illustrative examples, such as "your creditworthiness and credit history"].
Sample Clause A-5, Alternative 2:
We may disclose all of the information we collect, as described [describe location in the notice, such as "above" or "below"] to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements.

A-6. Explanation of opt out right (institutions that disclose outside of the exceptions).
A licensee may use this clause, as applicable, to meet the requirement of Section 7A(6) to provide an explanation of the consumer's right to opt out of the disclosure of nonpublic personal information to nonaffiliated third parties, including the method(s) by which the consumer may exercise that right. The licensee may use this clause if the licensee discloses nonpublic personal information other than as permitted by the exceptions in Sections 15, 16 and 17.
Sample Clause A-6:
If you prefer that we not disclose nonpublic personal information about you to nonaffiliated third parties, you may opt out of those disclosures, that is, you may direct us not to make those disclosures (other than disclosures permitted by law). If you wish to opt out of disclosures to nonaffiliated third parties, you may [describe a reasonable means of opting out, such as "call the following toll-free number: (insert number)].

A-7. Confidentiality and security (all institutions).
A licensee may use this clause, as applicable, to meet the requirement of Section 7A(8) to describe its policies and practices with respect to protecting the confidentiality and security of nonpublic personal information.
Sample Clause A-7:
We restrict access to nonpublic personal information about you to [provide an appropriate description, such as "those employees who need to know that information to provide products or services to you"]. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

APPENDIX B – FEDERAL MODEL PRIVACY FORM

Licensees, including a group of financial holding company affiliates that use a common privacy notice, may use the Federal Model Privacy Form, if the Form is accurate for each institution that uses the Form. (Note that disclosure of certain information, such as assets, income and information from a consumer reporting agency, may give rise to obligations under the federal Fair Credit Reporting Act, such as a requirement to permit a consumer to opt of disclosures to affiliates or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.)

General Instructions

1. How the Model Privacy Form is used.

(a) The Model Form may be used, at the option of a "licensee", including a group of licenses or other financial institutions that use a common privacy notice, to meet the content requirements of the privacy notice and opt-out notice set forth in Sections 7 and 8 of this Regulation.

(b) The Model Form is a standardized form, including page layout, content, format, style, pagination, and shading. Licensees seeking to obtain the safe harbor through use of the Model Form may modify it only as described in these Instructions.

(c) Note that disclosure of certain information, such as assets, income, and information from a consumer reporting agency, may give rise to obligations under the federal Fair Credit Reporting Act (FCRA), codified at 15 U.S.C. §§ 1681-1681x, such as a requirement to permit a consumer to opt out of disclosures to affiliates, or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.

(d) The word "customer" may be replaced by the word "member," whenever it appears in the Model Form, as appropriate.

2. The Contents of the Model Privacy Form

The Model Form consists of two pages, which may be printed on both sides of a single sheet of paper or may appear on two separate pages. Where a licensee provides a long list of licensees or financial institutions at the end of the Model Form in accordance with Instruction B3(a)(i), or provides additional information in accordance with Instruction B3(c) and such list or additional information exceeds the space available on Page Two of the Model Form, such list or additional information may extend to a third page.

(a) Page One. The first page consists of the following components:

(1) Date last revised (upper right-hand corner)
(2) Title
(3) Key frame (Why? What? How?)
(4) Disclosure table ("Reasons we can share your personal information")
(5) "To limit our sharing" box, as needed, for the licensee's opt-out information
(6) "Questions" box, for customer service contact information
(7) Mail-in opt-out form, as needed

(b) Page Two. The second page consists of the following components:

(1) Heading (Page 2)
(2) Frequently Asked Question ("Who we are" and "What we do")
(3) Definitions
(4) "Other important information" box, as needed

3. The format of the Model Privacy Form

The format of the Model Form may be modified only as described below:

(a) Easily readable type font. Licensees that use the Model Form must use an easily readable type font. While a number of factors together produce easily readable font, licensees are required to use a minimum of 10-point font (unless otherwise expressly permitted in these Instructions) and sufficient spacing between lines.

(b) Logo. A licensee may include a corporate logo on any page of the notice, so long as it does not interfere with the readability of the Model Form or the space constraints of each page.

(c) Page size and orientation. Each page of the Model Form must be printed in portrait orientation, the size of which must be sufficient to meet the layout and minimum font size requirements, with sufficient white space on the top, bottom, and sides of the content.

(d) Color. The Model Form must be printed on white or light color paper (such as cream) with black or other contrasting ink color. Spot color may be used to achieve visual interest, so long as the color contrast is distinctive and the color does not detract from the readability of the Model Form. Logos may also be printed in color.

(e) Languages. The Model Form may be translated into languages other than English.

B. Information Required in the Model Privacy Form

The information in the Model Form may be modified only as described below:

1. Name of licensee or group of affiliated licensees or institutions providing the notice.

Insert the name of the licensee providing the notice, or a common identity of the affiliated licenses or financial institutions jointly providing the notice on the form, wherever [name of licensee] appears.

2. Page One

(a) Last revised date. The licensee must insert in the upper right-hand corner the date on which the notice was last revised. The information shall appear in minimum 8-point font as "rev. [month/year]" using either the name or number of the month, such as "rev. July 2016" or "rev. 7/16."

(b) General instructions for the "What?" box.

(i) The bulleted list identifies the types of personal information that the licensee collects and shares. All licensees must use the term "Social Security Number" in the first bullet.

(ii) A licensee must use five (5) of the following terms, to complete the bulleted list: income; account balances; payment history; transaction history; transaction or loss history; credit history; credit scores; assets; investment experiences; credit –based insurance scores; insurance claim history; medical information; overdraft history; purchase history; account transactions; risk tolerance; medical related debts; credit card or other debt; mortgage rates and payments; retirement assets; checking account information; employment information; wire transfer instructions.

(c) General instructions for the disclosure table. The left column lists reasons for sharing or using personal information. Each reason correlates to a specific legal provision described in Paragraph 2(d) of this Instruction. In the middle column, each licensee must provide a "Yes" or "no" response that accurately reflects its information-sharing policies and practices with respect to the reason listed on the left. In the right column, each licensee must provide in each box one of the following three (3) responses, as applicable, that reflects whether a consumer can limit such sharing:

"Yes," if it is required to or voluntarily provides an opt-out; "No," if it does not provide an opt-out; or

"We don't share," if it answers "No" in the middle column.

Only the sixth row ("For our affiliates to market to you") may be omitted at the option of the licensee. See Paragraph 2(d)(6) of this instruction.

(d)Specific disclosures and corresponding legal provisions

(i) For our everyday business purposes. This reason incorporates sharing information under Sections 16 and 17 of this Regulation and with service providers pursuant to Section 15 of this Regulation, other than the disclosures described in Paragraphs (2)(d)(ii) or (2)(d)(iii) of this instruction.

(ii) For our marketing purposes. This reason incorporates sharing information with service providers by a licensee for its own marketing pursuant to Section 15 of this Regulation. A licensee that shares for this reason may choose to provide an opt-out.

(iii) For joint marketing with other financial companies. This reason incorporates sharing information under joint marketing agreements between 2 or more licensees or financial institutions and with any service provider used in conjunction with such agreement pursuant to Section 15 of this Regulation. A licensee that shares for this reason may choose to provide and opt-out.

(iv) For our affiliates' everyday business purposes- information about transactions and experiences. This reason incorporates sharing information specified in Sections 603(d)(2)(A)(i) and (ii) of the FCRA. A licensee that shares information for this reason may choose to provide an opt-out.

(v) For our affiliates' everyday business purposes- information about creditworthiness. This reason incorporates sharing information pursuant to Section 603(d)(2)(A)(iii) of the FCRA. A licensee that shares information for this reason must provide an opt-out.

(vi) For our affiliates to market to you. This reason incorporates sharing information specified in Section 24 of the FCRA. This reason may be omitted from the disclosure table when" the licensee does not have affiliates (or does not disclose personal information to its affiliates); the licensee's affiliates do not use personal information in a manner that requires an opt-out; or the licensee provides the affiliate marketing notice separately. Licensees that include this reason must provide an opt-out of indefinite duration. A licensee that is required to provide an affiliate marketing opt-out, but does not include that opt-out in the Model Form under this part, must comply with Section 624 of the FCRA and this Regulation with respect to the initial notice and opt-out and any subsequent renewal notice and opt-out. A licensee not required to provide an opt-out under this subparagraph may elect to include this reason in the Model Form.

(vii) For nonaffiliates to market to you. This reason incorporates sharing described in Sections 8 and 12(a) of this Regulation. A licensee that shares personal information for this reason must provide an opt-out.

(e) To limit our sharing. A licensee must include this section of the Model Form only if it provides an opt-out. The word "choice" may be written in either the singular or plural, as appropriate. Licensees must select one or more of the applicable opt-out methods described: telephone, such as by a toll-free number; a web site; or use of a mail-in opt-out form. Licensees may include the word "toll-free" before telephone, as appropriate. A licensee that allows consumer to opt out online must provide either a specific web address that takes consumers directly to the opt-out page or a general web address that provides a clear and conspicuous direct link to the opt-out page. The opt-out choices made available to the consumer who contacts the licensee through these methods must correspond accurately to the "Yes" response in the third column of the disclosure table. In the part entitled "Please note," licensees may insert a number that is 30 days or greater in the space marked "[30]." Instructions on voluntary or state privacy law opt-out information are in Paragraph 2(g)(v) of these Instructions.

(f) Questions box. Customer service contact information must be inserted as appropriate where [phone number] or [web site] appear. Licenses may elect to provide either a phone number, such as a toll-free number, or a web address, or both. Licensees may include the words "toll-free" before the telephone number, as appropriate.

(g) Mail-in opt-out form. Licensees must include this mail-in form only if they state in the "To limit our sharing" box that consumers can opt out by mail. The mail-in form must provide opt-out options that correspond accurately to the "Yes" responses in the third column of the disclosure table. Licensees that require consumers to provide only name and address may omit the section identified as "[account #]." Licensees that require additional or different information, such as a random opt-out election should modify the "[account#]" reference accordingly. This includes licensees that require customers with multiple accounts to identify each account to which the opt-out should apply. A licensee must enter its opt-out mailing address in the far right of this form (see version3); or below the form (see version 4). The reverse side of the mail-in opt-out form must not include any content of the Model Form.

(i) Joint accountholder. Only licensees that provide their joint accountholders the choice to opt out for only one accountholder, in accordance with Paragraph 3(a)(5) of these Instructions, must include in the far left column of the mail-in form the following statement:

If you have a joint account, your choice(s) will apply to everyone on your account unless you mark below

[] Apply my choice(s) only to me.

The word "choice" may be written in either the singular or plural, as appropriate. Licensees that provide insurance products or services provide this option, and elect to use the Model Form may substitute the word "policy" for "account" in this statement. Licensees that do not provide this option may eliminate this left column from the mail-in form.

(ii) FRCA Section 603(d)(2)(A)(iii) opt-out. If the licensee shares personal information pursuant to Section 603(d)(A)(iii) of the FCRA, it must include in the mail-in opt-out form the following statement:

[] Do not share information about my creditworthiness with you affiliates for their everyday business purposes.

(iii) FCRA Section 624 opt-out. If the licensee uses Section 624 of the FCRA, in accordance with paragraph 2(d)(6) of these Instructions, it must include in the mail-in opt-out form the following statement:

[] Do not allow your affiliates to use my personal information to market to me.

(iv) Nonaffiliate opt-out. If the licensee shares personal information pursuant to Section 12(a) of this Regulation], it must include in the mail-in opt-out form the following statement:
[] Do not share my personal information with nonaffiliates to market their products and services to me.

(v) Additional opt-outs. Licensees that use the disclosure table to provide opt out options beyond those required by Federal law must provide those opt-outs in this section of the Model Form. A licensee that chooses to offer an opt-out for its own marketing in the mail-in opt-out form must include one of the two following statements:
[] Do not share my personal information to market to me. OR
[] Do not use my personal information to market to me.
A licensee that chooses to offer an opt-out for joint marketing must include the following statement:
[] Do not share my personal information with other financial institutions to jointly market to me.

(h) Barcodes. A licensee may elect to include a barcode and/or "tagline" (an internal identifier) in 6-point type at the bottom of page one, as needed for information internal to the licensee, so long as these do not interfere with the clarity or text of the form.

3. Page Two

(a) General Instructions for the Questions. Certain Questions on the Model Form may be customized as follows:

(i) "Who is providing this notice?" This question may be omitted where only one licensee provides the Model Form and that licensee is clearly identified in the title on Page One. Two or more licensees or financial institutions that jointly provide the Model Form must use this question to identify themselves as required by Section 11(F) of this Regulation. Where the list of licensees or financial institutions exceeds four (4) lines, the licensee must describe in the response to this question the general types of licensees or financial institutions jointly providing the notice and must separately identify those licensees or financial institutions, in minimum 8-point font, directly following the "Other important information" box, or, if that box is not included in the licensee's form, directly following the "Definitions." The list may appear in a multi-column format.

(ii) "How does [name of licensee] protect my personal information?" The licensee may only provide additional information pertaining to its safeguards practices following the designated response to this question. Such information may include information about the licensee's use of cookies or other measures it uses to safeguard personal information. Licensees are limited to a maximum of 30 additional words.

(iii) "How does [name of licensee] collect my personal information?" Licensees must use five (5) of the following terms to complete the bulleted list for this question: open an account; deposit money; pay your bills; apply for a loan; use your credit or debit card; seek financial or tax advice; apply for insurance; pay insurance premiums; file an insurance claim; seek advice about your investments; buy securities from us; sell securities to us; direct us to buy securities; direct us to sell your securities; make deposits or withdrawals from your account; enter into an investment advisory contract; give us you income information; provide employment information; tell us about your investment or retirement portfolio; tell us about your investment or retirement earnings; apply for financing; apply for a lease; provide account information; give us you contact information; pay us by check; give us your wage statements ; provide your mortgage information; make a wire transfer; tell us who receives the money; tell us where to send the money; show your government-issued ID; show your driver's license; order a commodity futures or option trade.
Licensees that collect personal information from their affiliates and/or credit bureaus must include the following statement after the bulleted list; "We also collect your personal information from others, such as credit bureaus, affiliates, or other companies." Licensees that do not collect personal information from their affiliates or credit bureaus but do collect information from other companies must include the following statement instead: "We also collect your personal information from other companies." Only licensees that do not collect any personal information from affiliates, credit bureaus, or other companies can omit both statements.

(iv) "Why can't I limit all sharing?" Licensees that describe state privacy law provisions in the "Other important information" box must use the bracketed sentence: "See below for more on your rights under state law." Other licensees must omit this sentence.

(v) "What happens when I limit sharing for an account I hold jointly with someone else?" Only licensees that provide opt-out options must use this question. Other licensees must omit this question. Licensees must choose one of the following tow statements to respond to this question: "Your choices will apply to

everyone on your account – unless you tell us otherwise." Licensees may substitute the word policy" for "account" in these statements.

(b) General Instructions for the Definitions. The licensee must customize the space below the responses to the three definitions in this section. This specific information must be in italicized lettering to set off the information from the standardized definitions.

(i) Affiliates. As required by Section 7(A)(3) of this Regulation, where [affiliate information] appears, the licensee must:

(a) If it has no affiliates, state: "[name of licensee] has no affiliates";

(b) If it has affiliates but does not share personal information with them, state: "[name of licensee] does not share with our affiliates"; or

(c) If it shares with its affiliates, state, as applicable: "Our affiliates include companies with a [common corporate identity of licensee] name; financial companies such as [insert illustrative list of companies]; nonfinancial companies, such as [insert illustrative list of companies]; and others, such as [insert illustrative list]."

(ii) Nonaffiliates. As required by Section 7(c)(3) of this Regulation, where [nonaffiliated information] appears, the licensee must:

(a) If it does not share with nonaffiliated third parties, state: "[name of licensee] does not share with nonaffiliates so they can market to you"; or

(b) If it shares with nonaffiliated third parties, state, as applicable: "Nonaffiliates we share with can include [list categories of companies such as mortgage companies, insurance companies, direct marketing companies, and nonprofit organizations]."

(iii) Joint Marketing. As required by Section 15 of this Regulation, where [joint marketing] appears, the licensee must:

(a) If it does not engage in joint marketing, state: "[name of licensee] doesn't jointly market", or

(b) If it shares personal information for joint marketing, state, as applicable: "Our joint marketing partners include [list categories of companies such as credit card companies]."

(c) General instruction for the "Other important information" box. This box is optional. The space provided for information in this box is not limited, and an additional page may be used if necessary. Only the following types of information can appear in this box:

(i) State and/or international privacy law information; and/or

(ii) A form by which the consumer may acknowledge receipt of the notice.

Rev. [insert date]

Version 1:
Model Form with No Opt-Out

FACTS	**WHAT DOES [Name of Licensee] DO WITH YOUR PERSONAL INFORMATION?**
Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: Social Security number and [income] [account balances] and [payment history] [credit history] and [credit scores] When you are *no longer* our customer, we continue to share your information as described in this notice.
How?	All financial companies need to share **customers'** personal information to run their everyday business. In the section below, we list the reasons financial companies can share their **customers'** personal information; the reasons [name of financial institution**]** chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	**Does [name of licensee] share?**	**Can you limit this sharing?**
For our everyday business purposes- such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus		
For our marketing purposes- to offer our products and services to you		
For joint marketing with other financial companies		
For our affiliates' everyday business purposes- information about your transactions and experiences		
For our affiliates' everyday business purposes- information about your creditworthiness		
For our affiliates to market to you		
For nonaffiliates to market to you		

Questions?	Call [phone number] or go to [web site]

Who we are	
Who is providing this notice?	[insert]
What we do	
How does [name of licensee] protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. [insert]
How does [name of licensee] collect my personal information?	We collect your personal information, for example, when you [open an account] or [deposit money] [pay your bills] or [apply for a loan] [use your credit or debit card] [We also collect your personal information from other companies.] OR [We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.]
Why can't I limit all sharing?	Federal law gives you the right to limit only sharing for affiliates' everyday business purposes – information about your creditworthiness affiliates from using your information to market to you sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing. [See below for more on your rights under state law.]
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. [affiliate information]
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. [nonaffiliated information]
Joint Marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. [joint marketing information]
Other important information	
[insert other important information]	

Version 2: Model Form with Opt-Out by telephone and/or Online

Rev. [insert date]

FACTS	**WHAT DOES [Name of Licensee] DO WITH YOUR PERSONAL INFORMATION?**
Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: Social Security number and [income] [account balances] and [payment history] [credit history] and [credit scores] When you are *no longer* our customer, we continue to share your information as described in this notice.
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons [name of financial institution] chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	**Does [name of licensee] share?**	**Can you limit this sharing?**
For our everyday business purposes- such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus		
For our marketing purposes- to offer our products and services to you		
For joint marketing with other financial companies		
For our affiliates' everyday business purposes- information about your transactions and experiences		
For our affiliates' everyday business purposes- information about your creditworthiness		
For our affiliates to market to you		
For nonaffiliates to market to you		

To limit our sharing	Call [phone number] – our menu will prompt you through your choice(s) or Visit us online: [website] **Please note:** If you are a *new* customer, we can begin sharing your information [30] days from the date we sent this notice. When you are no longer our customer, we continue to share your information as described in this notice. However, you can contact us at any time to limit our sharing.
Questions?	Call [phone number] or go to [web site]

Who we are	
Who is providing this notice?	[insert]
What we do	
How does **[name of licensee]** protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. [insert]
How does **[name of licensee]** collect my personal information?	We collect your personal information, for example, when you [open an account] or [deposit money] [pay your bills] or [apply for a loan] [use your credit or debit card] [We also collect your personal information from other companies.] OR [We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.]
Why can't I limit all sharing?	Federal law gives you the right to limit only sharing for affiliates' everyday business purposes – information about your creditworthiness affiliates from using your information to market to you sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing**.** [See below for more on your rights under state law.]
What happens when I limit sharing for an account I hold jointly with someone else?	[Your choices will apply to everyone on your account.] OR [Your choices will apply to everyone on your account – unless you tell us otherwise.]
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. [affiliate information]
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. [nonaffiliated information]
Joint Marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. [joint marketing information]
Other important information	
[insert other important information]	

Version 3: Model Form with Mail-in Opt-Out Form

Rev. [insert date]

FACTS	**WHAT DOES [Name of Licensee] DO WITH YOUR PERSONAL INFORMATION?**
Why?	Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.
What?	The types of personal information we collect and share depend on the product or service you have with us. This information can include: Social Security number and [income] [account balances] and [payment history] [credit history] and [credit scores]
How?	All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons [name of financial institution] chooses to share; and whether you can limit this sharing.

Reasons we can share your personal information	**Does [name of licensee] share?**	**Can you limit this sharing?**
For our everyday business purposes- such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, or report to credit bureaus		
For our marketing purposes- to offer our products and services to you		
For joint marketing with other financial companies		
For our affiliates' everyday business purposes- information about your transactions and experiences		
For our affiliates' everyday business purposes- information about your creditworthiness		
For our affiliates to market to you		
For nonaffiliates to market to you		

To limit our sharing	Call **[phone number]** – our menu will prompt you through your choice(s) or Visit us online: **[website] or** Mail the form below **Please note:** If you are a *new* customer, we can begin sharing your information **[30]** days from the date we sent this notice. When you are *no longer* our customer, we continue to share your information as described in this notice. However, you can contact us at any time to limit our sharing.
Questions?	Call **[phone number]** or go to **[web site]**

Mail-in Form	
Leave Blank OR [If you have a joint account, your choice(s) will apply to everyone on your account unless you mark below. □ Apply my choices only to me]	Mark any/all you want to limit: □ Do not share information about my creditworthiness with your affiliates for their everyday business purposes. □Do not allow your affiliates to use my personal information to market to me. □Do not share my personal information with nonaffiliates to market their products and services to me. Name Address City, State, Zip [Account #]
Mail To:	[Name of Licensee] [Address] [City],[ST][ZIP]

Who we are	
Who is providing this notice?	[insert]
What we do	
How does **[name of licensee]** protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. **[insert]**
How does **[name of licensee]** collect my personal information?	We collect your personal information, for example, when you **[open an account]** or **[deposit money]** **[pay your bills]** or **[apply for a loan]** **[use your credit or debit card]** **[We also collect your personal information from other companies.]** OR **[We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.]**
Why can't I limit all sharing?	Federal law gives you the right to limit only sharing for affiliates' everyday business purposes – information about your creditworthiness affiliates from using your information to market to you sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing**. [See below for more on your rights under state law.]**
What happens when I limit sharing for an account I hold jointly with someone else?	**[Your choices will apply to everyone on your account**.] OR **[Your choices will apply to everyone on your account – unless you tell us otherwise.]**
Definitions	
Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. [affiliate information]
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. [nonaffiliated information]
Joint Marketing	A formal agreement between nonaffiliated financial companies that together market financial products or services to you. [joint marketing information]
Other important information	
[insert other important information]	

Version 4: Optional Mail-in Form

<table>
<tr><td colspan="2">Mail-in Form</td></tr>
<tr><td>Leave Blank
OR
[If you have a joint account, your choice(s) will apply to everyone on your account unless you mark below.
□ Apply my choices only to me]</td><td>Mark any/all you want to limit:
□ Do not share information about my creditworthiness with your affiliates for their everyday business purposes.
□Do not allow your affiliates to use my personal information to market to me.
□Do not share my personal information with nonaffiliates to market their products and services to me.

<table><tr><td>Name</td><td></td></tr><tr><td>Address
City, State, Zip</td><td></td></tr><tr><td>[Account #]</td><td></td></tr></table></td></tr>
<tr><td>Mail To:</td><td>[Name of Licensee]
[Address 1], [Address 2],
[City],[ST][ZIP]</td></tr>
</table>