Title 19: Insurance

Part 3: Accident, Health, and Medicare Supplement Insurance

Part 3 Chapter 1: (LA&H 57-2) Payment of Health, Accident & Hospitalization Premium to Company or State Agency.

Rule 1.01

TO ALL COMPANIES WRITING HEALTH, ACCIDENT & HOSPITALIZATION INSURANCE IN MISSISSIPPI.

It has come to the attention of the State Insurance Department that certain agents in the State make a practice of having the insured's check made to the agent personally rather than to the company or state agent. In order to provide protection to the insured, bothcompanies and agents are hereby advised that effective November 15, 1957, ALL CHECKS SHALL BE MADE PAYABLE EITHER TO THE COMPANY OR TOAN AUTHORIZED STATE AGENCY, rather than to the individual agent making thesale.

The companies are requested to incorporate in their receipts in bold type "CHECK SHOULD BE MADE PAYABLE TO THE COMPANY OR STATE AGENCY; DO NOT MAKE CHECK PAYABLE TO SALESMAN." Companies having printed receipts already on hand may use a rubber stamp until new forms are printed.

This Order is prompted by the following circumstances: (1) over-charges on the part of salesmen who have checks made payable to themselves and in which instances the company is unable to ascertain the amount actually charged; (2) collection of annual premiums by agents and remittance of partial premiums only; (3) collection of premiums and failure to submit application or premium to the company.

Willful violation of this ruling on the part of an agent will result in revocation of his license.

Please acknowledge receipt of this Order by letter to the Department.

This 30thDay of October, 1957.

Source: *Miss Code Ann.* §§ 83-5-1; 83-5-29 (Rev. 2011)

Part 3 Chapter 2: (LA&H 62-2) Health and Accident Payment of Claims.

Rule 2.01

MEMORANDUM TO ALL COMPANIES WRITING HEALTH AND ACCIDENT INSURANCE:

The Department is being deluged with letters from insureds requesting assistance in the payment of claims. A great number of the letters from the insureds state that an "agent" told them to write the Department and that the Department could get these claims paid.It is apparent that many agents are using this method to reflect upon and embarrass competitive companies. Such action on the part of either agents or companies will not be tolerated. It will be an impossible task for the Department to bulletin each individual Accident and Health agent. For that reason we are requesting the various companies operating in Mississippi to cooperate with us in the following manner.

Bulletin your individual agents, either through the home office or district office, warning them against referring any claim to this office which does not involve his or her company. Further advise the individual agents that loose remarks about the claim payment record of any competing company will immediately result in a hearing before the Department and may result in a revocation of license.

Your usual cooperation will be sincerely appreciated.

November 8, 1962

Source: *Miss Code Ann* § 83-5-33 (Rev. 2011)

Part 3 Chapter 3: (LA&H 62-1) Clarification of "Non-Cancelable" and "Guaranteed Renewable"

Rule 3.01

WHEREAS, a marked degree of confusion exists in this state by reason of various interpretations relative to use of the terms "non-cancellable" and guaranteed renewable"insurance, it is deemed in the public interest for the Mississippi Insurance Department toadopt the interpretation of the National Association of Insurance Commissions with reference to such terms approved in December 1959, which interpretation is as follows:

The terms "non-cancellable" or "non-cancelable and guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the policy(1) until at least age 50, or (2) in the case of a policy issued after age 44, forat least five years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.

Except as provided above, the term "guaranteed renewable" may be usedonly in a policy which the insured has the right to continue in force by the timely payment of premiums (1) until at least age 50, or (2) in the case of a policy issued after age 44, for at least five years from its date of issue, during which period the insurer has noright to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premiumrates by classes.

The foregoing limitation on use of the term ‘non-cancellable” shall also apply to any synonymous term such as “ not cancellable” and the limitation on use of the term “guaranteed renewable” shall apply to any synonymous term such as “guaranteed continuable.”

Nothing herein contained is intended to restrict the development of policies having other guarantees of renewability, or to prevent the accurate description of their terms of renewability or the classification of such policies as guaranteed renewable or non-cancellable for any period during which they may actually be such, provided the terms used to describe them in policy contracts andadvertising are not such as may readily be confused with the above terms.

Adoption of the above interpretation shall be effective as of the date of this Order as to new policy approvals; any policy forms now approved which are in conflict with the above interpretation are hereby disapproved for sale in the State of Mississippi on and after January 1, 1963.

So Ordered this 24TH Day of July, 1962.

Source: *Miss code Ann* §§83-5-1; 83-5-29 (Rev. 2011)

Part 3 Chapter 4: (LA&H 73-4) Accident and Health Insurance Policies, Rates and Other Endorsement Filings (As Amended).

Rule 4.01

Whereas, Section 83-9-5(7), Mississippi Code of 1972, Annotated, provides that the commissioner of Insurance may make reasonable rules and regulations concerning the procedure for the filing or submission of accident and sickness insurance policies; and

Whereas, there seems to have been some misunderstanding in the past as to the requirements of such filings;

It is, therefore, ordered this date that every insurance company, either foreign or domestic, authorized to do accident and sickness business in the State of Mississippi shall, before any policy is issued, file a copy of such policy, accompanied by a rate book or a rate sheet applicable to such policy. In case of any change, including a change of premium rate on any accident and sickness policy, such rate shall be filed with the Department of Insurance, together with information indicating to what policy same is applicable, the date such change in premium rate will be applicable, and all other information relevant to such change in rate. No premium or rate of premium shall be changed by any company, applicable to any accident and sickness policy until such change has been made in the manner herein provided and acknowledgment of such filing made by the Department of Insurance.

No insurance company shall ever, under any circumstances, attempt to place any change of rate or any other change in a policy form into effect except after such change has been filed in this office and acknowledged, and where required by law, approved. In particular, any notice to an insured that a change in policy is being made, either a rate or other change, is prohibited except

after filing of such change, acknowledgment thereof, and where required by law, approval. Any change as to a policy already issued may be effected only by endorsement attached to and made a part of such policy.

Additionally, no rate increase shall be implemented by any insurance company applicable to any accident and sickness policy unless written notice is provided to the policyholder at least sixty (60) days prior to the effective date of the increase. Notice of the rate increase may be sent by U.S. mail or electronically where the policyholder conducts transactions with the insurance company electronically.

Every policy or other filing provided for under these rules shall be accompanied by a cover letter, in duplicate, setting out the number and a brief description of such form.

All policy filings must comply with all provisions of the law of this State applicable thereto and this and all other rules of this office pertaining thereto. Nothing herein shall be interpreted as rescinding any other rule and regulation, but these rules are to be interpreted as cumulative to the requirements of any other rules pertaining to the subject matter hereof.

This Regulation shall become effective thirty (30) days after filing with the Office of the Secretary of State of the State of Mississippi.

Source: *Miss Code Ann.* §§83-5-1; 83-5-29; 83-9-5(7) (Rev. 2011)

Part 3 Chapter 5: (LA&H 74-3) Advertisement of Accident and Health Insurance**.**

Rule 5.01: Purpose

The purpose of these rules is to assure truthful and adequate disclosure of all material and relevant information in the advertising of accident and sickness insurance.This purpose is intended to be accomplished by the establishment of, and adherence to, certain minimum standards and guidelines of conduct in the advertising of accident and sickness insurance in a manner which prevents unfair competition among insurers and is conducive to the accurate presentation and description to the insurance buying public of a policy of such insurance offered through various advertising media.

Source: *Miss Code Ann* §§83-5-29; 83-5-35 (Rev. 2011)

Rule 5.02: Applicability

A. These rules shall apply to any accident and sickness insurance "advertisement", as that term is hereinafter defined, intended for presentation, distribution or dissemination in this State when such presentation, distribution or dissemination is made either directly or indirectly by or on behalf of an insurer, agent, broker or solicitor as those terms are defined in the Insurance Code of this State and these rules.

B. Every insurer shall establish and at all times maintain a system of controlover the content, form and method of dissemination of all advertisements of its policies. All such advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer whose policies are so advertised.

Source: *Miss Code Ann* §83-5-29 (Rev. 2011)

Rule 5.03: Definitions

A. An advertisement for the purpose of these rules shall include:

1. Printed and published material, audio visual material, and descriptiveliterature of an insurer used in direct mail, newspapers, magazines, radio scripts,TV scripts, billboards and similar displays; and

2. Descriptive literature and sales aids of all kinds issued by an insurer, agent or broker for presentation to members of the insurance buying public, including but not limited to circulars, leaflets, booklets, depictions, illustrations and form letters; and

3. Prepared sales talks, presentations and material for use by agents, brokers and solicitors.

B. "Policy" for the purpose of these rules shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement which provides accident or sickness benefits, or medical, surgical or hospital expense benefits, whether on an indemnity, reimbursement, service or prepaid basis, except when issued in connection with another kind of insurance other than life, and except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts.

C. "Insurer" for the purpose of these rules shall include any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds, fraternal benefit society, health maintenance organization, and any other legal entity which is defined as an "insurer" in the Insurance Code of this State and is engaged in the advertisement of a policy as "policy" is herein defined.

D. "Exception" for the purpose of these rules shall mean any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

E. "Reduction" for the purpose of these rules shall mean any provision whichreduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction not been used.

F. “Limitation” for the purpose of these rules shall mean any provision whichrestricts coverage under the policy other than an exception or a reduction.

G. “Institutional Advertisement” for the purpose of these rules shall mean an advertisement having as its sole purpose the promotion of the Reader’s or Viewer’s interest in the concept of accident and sickness insurance, or the promotion of the insurer.

H. “Invitation to Inquire” for the purpose of these rules shall mean an advertisement having as its objective the creation of a desire to inquire further about the production and which is limited to a brief description of the loss for which the benefit is payable, and which may contain:

1. The dollar amount of benefit payable, or

2. The period of time during which the benefit is payable; provided the advertisement does not refer to cost. An advertisement which specifies either the dollar amount of benefit payable or the period of time during which the benefit is payable shall contain a provision in effect as follows: “For costs and further details of the coverage, including exclusions, any reductions or limitations and the terms under which the policy may be continued in force, see your agent or write to the company.”

I. “Invitation to Contract” for the purpose of these rules shall mean anadvertisement which is neither an invitation to inquire nor an institutionaladvertisement.

Source: *Miss Code Ann* §83-5-29 (Rev. 2011)

Rule 5.04: Method OfDisclosure Of Required Information

All information required to be disclosed by these rules shall be set out conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisement so as to be confusing or misleading.

Source: *Miss Code Ann* §83-5-29 (Rev. 2011)

Rule 5.05: Form AndContent Of Advertisements

A. The format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed.

B. Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implication or by familiarity with insurance terminology, shall not be used.

Source: *Miss Code Ann* §83-5-29 (Rev. 2011)

Rule 5.06: Advertisements Of Benefits Payable, Losses Covered Or Premiums Payable

A. Deceptive Words, Phrases Or Illustrations Prohibited.

1. No advertisement shall omit information or use word, phrases, statements, references or illustrations if the omission of such information or use of such words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

2. No advertisement shall contain or use words or phrases such as, “all”; “full”; “complete”; “comprehensive”; “unlimited”; “up to”; “as high as”;“this policy will help pay your hospital and surgical bills”; “this policy will helpfill some of the gaps that Medicare and your present insurance leave out”; “thispolicy will help replace your income”(when used to express loss of time benefits);or similar words and phrases, in a manner which exaggerates any benefits beyondthe terms of the policy.

3. An advertisement shall not contain descriptions of a policy limitation, exception or reduction, worded in a positive manner to imply that it isa benefit, such as, describing a waiting period as a “benefit builder”, or stating “even pre-existing conditions are covered after two years”. Words and phrasesused in an advertisement to describe such policy limitations, exceptions andreductions shall fairly and accurately describe the negative features of suchlimitations, exceptions and reductions of the policy offered.

4. No advertisement of a benefit for which payment is conditional upon confinement in a hospital or similar facility shall use words or phrases such as “tax free”; “extra cash”; “extra income”; extra pay”; or substantially similarwords or phrases because such words and phrases have the capacity, tendencyor effect of misleading the public into believing that the policy advertised will,in some way, enable them to make a profit from being hospitalized.

5. No advertisement of a hospital or other similar facility confinement benefit shall advertise that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement. When the policy contains a limit on the number of days of coverage provided, such limit must appear in the advertisement.

6. No advertisement of a policy covering only one disease or a list of specified diseases shall imply coverage beyond the terms of the policy. Synonymous terms shall not be used to refer to any disease so as to imply broader coverage than is the fact.

7. An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or for specified accidents only, such as automobileaccidents, shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to,or substantially similar to the following: "THIS IS A LIMITED POLICY"; "THIS IS A CANCER ONLY POLICY";"THIS IS AN AUTOMOBILE ACCIDENT ONLY POLICY,"

8. An advertisement of a direct response insurance product shallnot imply that because "no insurance agent will call and no commissions willbe paid to agents" that it is "a low cost plan", or use other similar words orphrases because the cost of advertising and servicing such policies is a substantial cost in the marketing of a direct response insurance product.

B. Exceptions, Reductions and Limitations

1. When an advertisement which is an invitation to contract refers to either a dollar amount, or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall also disclose those exceptions, reductions and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity or tendency to mislead or deceive.

2. When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such loss, an advertisement which is subject to the requirements of the preceding paragraph shall disclose the existence of such periods.

3. An advertisement shall not use the words "only"; "just"; "merely"; "minimum" or similar words or phrases to describe the applicability of

anyexceptions and reductions, such as: “This policy is subject to the followingminimum exceptions and reductions”.

C. Pre-Existing Conditions

1. An advertisement which is subject to the requirements of Section 6-B shall, in negative terms, disclose the extent to which any loss is not covered ifthe cause of such loss is traceable to a condition existing prior to the effective date of the policy. The use of the term “pre-existing condition” without an appropriate definition or description shall not be used.

2. When a policy does not cover losses resulting from pre-existing conditions, no advertisement of the policy shall state or imply that the applicant’sphysical condition or medical history will not affect the issuance of the policy or payment of a claim thereunder. This rule prohibits the use of the phrase “nomedical examination required” and phrases of similar import, but does not prohibit explaining “automatic issue”. If an insurer requires a medical examination for a specified policy, the advertisement shall disclose that a medical examination is required.

3. When an advertisement contains an application form to be completed by the applicant and returned by mail for a direct response insurance product, such application form shall contain a question or statement which reflects the pre-existing condition provisions of the policy immediately preceding the blank space for the applicant’s signature. For example, such an application form shall contain a question or statement substantially as follows:

a. “Do you understand that this policy will not pay benefits during thefirst ___year(s) after the issue date for a disease or physical conditionwhich you now have or have had in the past? ( ) YES

Or substantially the following statement:

b.“I understand that the policy applied for will not pay benefits for anyloss incurred during the first ____year(s) after the issue date on account ofdisease or physical condition which I now have or have had in the past.”

Source: *Miss Code Ann* §83-5-29 (Rev. 2011)

Rule 5.07: Necessity ForDisclosing Policy Provisions Relating To Renewability, Cancellability And Termination

When an advertisement which is an invitation to contract refers to either a dollar amount or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, it shall disclose the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered or premiums because of age or for other reason, in a mannerwhich shall not minimize or render obscure the qualifying conditions.

Source: *Miss Code Ann* §83-5-29 (Rev. 2011)

Rule 5.08: Testimonials Or Endorsements By Third Parties

A. Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accuratelyreproduce. The insurer, in using a testimonial, makes as its own all of the statements contained herein, and the advertisement, including such statement, is subject to all the provisions of these rules.

B. If the person making a testimonial, an endorsement or an appraisal has a financial interest in the insurer, or a related entity as a stockholder, director, officer, employee, or otherwise, such fact shall be disclosed in the advertisement.If a person is compensated for making a testimonial, endorsement or appraisal, such fact shall be disclosed in the advertisement by language substantially as follows: “Paid Endorsement”. This rule does not require disclosure of union “scale” wages required by union rules if the payment is actually for such “scale’ for TV or radio performances. The payment of substantial amounts, directly or indirectly, for “travel and entertainment” for filming or recording of TV or radio advertisements remove the filming or recording from the category of an unsolicited testimonial and require disclosure of such compensation.

C. An advertisement shall not state or imply that an insurer or a policy has been approved or endorsed by any individual, group of individuals, society, association or other organizations, unless such is the fact, and unless any proprietary relationshipbetween an organization and the insurer is disclosed. If the entity making theendorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, such fact shall bedisclosed in the advertisement.

D. When a testimonial refers to benefits received under a policy, thespecific claim date, including claim number, date or loss, and other pertinent informationshall be retained by the insurer for inspection for a period of four years or until the filingof the next regular report on examination of the insurer, whichever is the longer period oftime.

Source: *Miss Code Ann* §83-5-29 (Rev. 2011)

Rule 5.09: Use Of Statistics

A. An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use

irrelevant facts, and shall not be used unless it accurately reflects all of the relevant facts. Such an advertisement shall not imply that such statistics are derived from the policy advertised unless such is the fact, and when applicable to other policies or plans shall specifically so state.

B. An advertisement shall not represent or imply that claim settlements by the insurer are “liberal” or “generous”, or use words of similar import, or that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used.

C. The source of any statistics used in an advertisement shall be identified in such advertisement.

Source: *Miss Code Ann* §83-5-29 (Rev. 2011)

Rule 5.10: Identification Of Plan Or Number Of Policies

A. When a choice of the amount of benefits is referred to, an advertisement which is an invitation to contract shall disclose that the amount of benefits provideddepends upon the plan selected and that the premium will vary with the amount of the benefits selected.

B. When an advertisement which is an invitation to contract refers to variousbenefits which may be contained in two or more policies, other than group master policies, the advertisement shall disclose that such benefits are provided only through a combination of such policies.

Source: *Miss Code Ann* §83-5-29 (Rev. 2011)

Rule 5.11: Disparaging Comparisons And Statements

An advertisement shall not directly or indirectly make unfair or incompletecomparisons of policies or benefits or comparisons of non-comparable policies ofother insurers, and shall not disparage competitors, their policies, services or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance.

Source: *Miss Code Ann* §83-5-29 (Rev. 2011)

Rule 5.12: Jurisdictional Licensing And Status Of Insurer

A. An advertisement which is intended to be seen or heard beyond the limitsof the jurisdiction in which the insurer is licensed shall not imply licensing beyond thoselimits.

B. An advertisement shall not create the impression directly or indirectly that the insurer, its financial condition or status, or the payment of its claims, or the merits, desirability, or advisability of its policy forms or kinds or plans of insurances are approved, endorsed, or accredited by any division or agency of this State or the United States Government.

Source: *Miss Code Ann* §83-5-29 (Rev. 2011)

Rule 5.13: Identity Of Insurer

The name of the actual insurer [and] shall be stated in all of its advertisements. The form number or numbers of the policy advertised shall be stated inan advertisement which is an invitation to contract. An advertisement shall not use a trade name, any insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device which without disclosing the name of the actual insurer would have the capacity band tendency to mislead or deceive as to the true identity of the insurer.

No advertisement shall use any combination of words, symbols, or physical materials which by their content, phraseology, shape, color or other characteristics are so similar to combination of words, symbols, or physical materials used by agencies of the federal government or of this State, or otherwise appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state, or federal government.

Source: *Miss Code Ann* §83-5-29 (Rev. 2011)

Rule 5.14: Group Or Quasi-Group Implications

An advertisement of a particular policy shall not state or imply that prospectiveinsureds become group or quasi-group members covered under a group policy and as such enjoy special rates or underwriting privileges, unless such is the fact.

Source: *Miss Code Ann* §83-5-29 (Rev. 2011)

Rule 5.15: Introductory, Initial or Special Offers

A. 1. An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory , initial or special offer, or that applicants will receive substantial advantages notavailable at a later date, or that the offer is available only to a specified group ofindividuals, unless such is the fact. An advertisement shall not contain phrases describing an enrollment period as "special", "limited", or similar words or phrases when the insurer uses such enrollment periods as the usual method of advertising accident and sickness insurance.

2. An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this State unlessthere has been a lapse of not less than six (6) months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement

shall indicate the date by which the applicant must mail the application which shall be not less than ten (10) days and not more than thirty(30) days from the date that such enrollment period is advertised for the first time. This rule applies to all advertising media, i.e., mail, newspapers, radio, television, magazines and periodicals, by any one insurer. It is inapplicable to solicitations of employees or members of a particular group or association which otherwise would be eligible under specific provisions of the Insurance Code for group, blanket or franchiseinsurance. The phrase “any one insurer” includes all the affiliated companies of a group of insurance companies under common management or control.

3. This rule prohibits any statement or implication to the effect thatonly a specific number of policies will be sold, or that a time is fixed for thediscontinuance of the sale of the particular policy advertised because of specialadvantages available in the policy, unless such is the fact.

4. The phrase “a particular insurance product” in paragraph (2)of this section means an insurance policy which provides substantial differentbenefits than those contained in any other policy. Different terms of renewability;an increase or decrease in the dollar amounts of benefits; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment periods.

B. An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears.

C. Special awards, such as a “safe drivers’ award” shall not be used inconnection with advertisements of accident or accident and sickness insurance.

Source: *Miss Code Ann* §83-5-29 (Rev. 2011)

Rule 5.16: Statements aboutan Insurer

An advertisement shall not contain statements which are untrue in fact, or byimplication misleading, with respect to the assets, corporate structure, financial standing,age or relative position of the insurer in the insurance business. An advertisement shallnot contain a recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extentof the recommendations.

Source: *Miss Code Ann* §83-5-29 (Rev. 2011)

Rule 5.17: Enforcement Procedures

A. Advertising File

Each insurer shall maintain at its home or principle office a complete file containing every printed, published or prepared advertisement of its individualpolicies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state whetheror not licensed in such other state, with a notation attached to each such advertisementwhich shall indicate the manner and extent of distribution and the form number of anypolicy advertised. Such file shall be subject to regular and periodical inspection by this Department. All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

B. Certificate of Compliance

Each insurer required to file an Annual Statement which is now or which thereafter becomes subject to the provisions of these rules must file with this Departmentwith its Annual Statement a Certificate of Compliance executed by an authorized officer of the insurer wherein it is stated that to the best of his knowledge, informationand belief the advertisements which were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with theprovisions of these rules and the Insurance Laws of this State as implemented andinterpreted by these rules.

Source: Miss Code Ann §83-5-29 (Rev. 2011)

Rule 5.18: Severability Provision

If any section or portion of a section of these rules, or the applicability thereof to any person or circumstance is held invalid by a court, the remainder of the rules or the applicability of such provision to other persons or circumstances, shall not be affected thereby.

Source: *Miss Code Ann* §§83-5-1; 83-5-29; (Rev. 2011)

Rule 5.19: Methods Of Interpretation And Guidelines

The methods of interpretation and guidelines in construing the foregoing rules andregulations shall so far as applicable be those adopted by the National Association of Insurance commissioners, as shown in Volume 1, 1972 Proceedings of the National Association of Insurance Commissioners, as found on Page 563 and the following pages thereof, pertaining to NAIC rules governing accident and sickness insurance, as amended by or supplemented by rules and interpretive guidelines concerning advertisements ofaccident and sickness insurance, Draft 4, dated April 16, 1974, of National Association ofInsurance Commissioners.

Source: *Miss Code Ann* § 83-5-29 (Rev. 2011)

Rule 5.20: Effective Date

These rules shall take effect and be in force from and after January 1, 1975.

Promulgated and Adopted, this the 25th day of November, 1974.

Source: *Miss Code Ann* §25-43-3.113 (Rev. 2010)

Part 3 Chapter 6: (86-102) Credit Life and Credit Disability**.**

Rule 6.01: Statutory Authority

This Regulation is promulgated by the Commissioner of Insurance of the State ofMississippi to implement Sections 83-5-1, 83-17-129, 83-17-229, and 83-17-231 of theMississippi Code of 1972, Annotated and Amended and Senate Bill 2482 as adopted bythe 1986 Session of the Mississippi Legislature, and in accordance with Section 25-43-1through 25-43-19, Mississippi Code of 1972, known as the Mississippi AdministrativeProcedures Law, do hereby promulgate the following Regulation with an effective dateof thirty (30) days after promulgation and filing with the Office of the Secretary of Stateupon compliance with the applicable statutes, to read as follows:

Source: *Miss Code Ann* §83-53-29 (Rev. 2011)

Rule 6.02: Purpose

The purpose of this Regulation is to promote the public welfare by regulating credit life and disability insurance.

Source: *Miss Code Ann* §83-53-29 (Rev. 2011)

Rule 6.03: Applicability

This Regulation shall apply to bona fide supervising general agents and insurance companies who engage in the business of credit life and credit disability insurance programs.

Source: *Miss Code Ann* §83-53-3 (Rev. 2011)

Rule 6.04: Bona Fide Supervising General Agents

A. The intent of this Regulation is to prohibit the use of a supervising general agent's license as a means to provide additional excessive commissions toa writing agent or creditor.

B. A bona fide supervising general agent shall be defined as an applicant applying for a license or a renewal thereof to permit said applicant to supervise the activities of soliciting agents, to service said business, and not for the purpose of obtaining an override commission on "controlled" business. For purposes of this Regulation, controlled business is defined as credit insurance premiums written by or for an agent or creditor in which the applicant, his relatives, business associates, employers, employees or any of them have an interest, either legal or beneficial.

C. Violations of the restrictions on compensation by the applicant or by theinsurance company, if found by the Commissioner, may lead to sanctions set forth by law to be assessed against the violating applicant or agent and/or the insurance company.

D. Bona fide agents applying for a credit life and credit disability supervising general agent's license shall make application for a privilege license to the Mississippi Insurance Department on a form prescribed by the Commissioner of Insurance. Said form will include the attachment of an affidavit appointment from each company appointing the supervising general agent which will expire December 31 of each year. The affidavit appointment must be renewed annually with the renewal of the supervising general agent's privilege license. The affidavit appointment will include the following information:

1. General information as to the insurance company appointing thesupervising general agent; whether the agent is incorporated or unincorporated.

2. Specific functions, authority and responsibilities granted by theinsurance company to the supervising general agent as designated in the agent's contract with the company.

3. Identification of the soliciting agent or sub-agent who will be under the supervision of the supervising general agent.

4. Any additional information the Commissioner may deem necessary todetermine the validity of the privilege license.

Upon withdrawal of the affidavit appointment, said insurance company will notify the supervising general agent that this appointment is terminated. The supervisinggeneral agent's privilege license will be classified invalid by the Mississippi Insurance Department unless a new affidavit appointment is submitted by a licensed credit life and credit disability insurance company within 30 calendar days of the effective termination date. Said insurance company will notify the Department and supervising general agent of this termination.

Source: *Miss Code Ann* §83-53-29 (Rev. 2011)

Rule 6.05: Effective Date

This Regulation shall become effective thirty (30) days after promulgation andfiling with the Secretary of State.

Source: *Miss Code Ann* §25-43-3.113 (Rev. 2010)

Rule 6.06: Enforcement

This Regulation shall be enforced in accordance with procedures established by Senate Bill 2482, Section 16 through Section 23.

PROMULGATED AND ADOPTED THIS THE 22nd DAY OF July, 1986

Source: *Miss Code Ann* §83-53-29 (Rev. 2011)

Part 3 Chapter 7: (88-102) Coordinating or Integrating Accident and Health Insurance Benefits**.**

Rule 7.01

Under the provisions of Title 83, Chapter 9, Mississippi Code of 1972, Annotated, it is hereby ordered and directed that on or after the effective date of this regulation, any insurer or nonprofit health service plan providing health and accident insurance or service contracts may file for approval policy forms or contracts which coordinate or integrate accident and health benefits with “other health plans” through the use of a coordination of benefits provision, a variable deductible, or similar provision.

It is not the purpose of this regulation to mandate or require coordination or integration of accident and health benefits with “other health plans”. A policy containing such provisions, however, must be consistent with the guidelines herein established.

“Other health plans” shall include any plan which provides insurance, reimbursement, or service benefits for hospital, surgical, or medical expenses; this shall include coverage under group or individual insurance policies, nonprofit health service plans, health maintenance organization subscriber contracts, self-insured group plans, worker’s compensation coverages, automobile or homeowners medical pay plans, and Medicare as permitted by federal law. It shall not include:

A. Medicaid; or

B. Hospital daily indemnity plans; or

C. Specified diseases only policies; or

D. Limited occurrence policies which provide only for intensive care or coronarycare at a hospital, first aid outpatient medical expenses resulting from accidents,or specified accidents such as travel accidents.

Any insurer or nonprofit health service plan issuing a policy or contract which coordinate or integrates benefits with "other health plans" must disclose this provision in its point of sale advertising materials. The definition of what constitutes "other health plans' must be clearly stated and set forth in the subject policy or contract.

This regulation shall supersede and fully replace any prior regulation concerning the prohibitions against coordinating or integrating or limiting accident and health insurance benefits, specifically including LA & H Regulation No. 84-102, dated September 13, 1984.

This regulation shall become effective thirty (30) days after its adoption and filing with the Mississippi Secretary of State's Office, as required by law.

Promulgated and filed with the Office of the Secretary of State on October 28, 1988.

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Chapter 8: (90-102) Long-Term Care Insurance Regulation.

Rule 8.01: Purpose

The purpose of the regulation is to promote the public interest, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Rule 8.02: Authority

This regulation is issued pursuant to the authority vested in the Commissioner under Miss. CodeAnn. Section 83-5-1 and Sections 83-5-29 through 83-5-51 (1972), as Amended, and other applicable provisions of the Mississippi Insurance Laws and is being adopted in accordance with the provisions of Miss Code Ann. Chapter 43, Title 25, and Mississippi Insurance Department Regulation Number 88-101, said regulation being the Rules of Practice and Procedure before the Mississippi Insurance Department.

Source: *Miss Code Ann* §§83-5-1; 83-5-29 (Rev. 2011)

Rule 8.03: Applicability and Scope

Except as otherwise specifically provided, this regulation applies to all long-term care insurance policies delivered or issued for delivery in this state on or after the effective date hereof, by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations and all similar organizations.

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Rule 8.04: Definitions

For the purpose of this regulation, the following terms shall have the following meanings:

A. "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, or maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. Long-term care insurance may be issued by insurers; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset –protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage.

B. "Applicant" means:

    1. In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits, and

    2. In the case of a group long-term care insurance policy, the proposed certificate holder.

C. "Certificate" means, for the purposes of this Regulation, any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

D. "Commissioner" means the Insurance Commissioner of this state.

E. "Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this state and issued to:

    1. One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a 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; or

2. Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

   a. Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

   b. has been maintained in good faith for purposes other thanobtaining insurance; or

3. An association or a trust or the trustee(s) of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the Commissioner that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaininginsurance, have been in active existence for at least one year; and have a constitution and bylaws which provide that:

   a. The association or associations hold regular meetings not less than annually to further purposes of the members;

   b. Except for credit unions, the association or associations collect dues or solicit contributions from members; and

   c. The members have voting privileges and representation on the governing board and committees.

   d. Thirty (30) days after such filing the association or associations will be deemed to satisfy such organizational requirements, unless the Commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

4. A group other than as described in Subsections E(1), E(2) and E(3), subject to a finding by the Commissioner that:

   a. The issuance of the group policy is not contrary to the best interest of the public;

   b. The issuance of the group policy would result in economies of acquisition or administration; and

   c. The benefits are reasonable in relation to the premiums charged.

F. “Policy” means, for the purposes of this Regulation, any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; nonprofit health, hospital, or medical service corporation; prepaid health plan; health maintenance organization or any similar organization.

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Rule 8.05: Policy Definitions

No long-term insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

A. “Acute condition” means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

B. “Home health care services” means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

C. “Medicare” shall be 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 1 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.

D. .“Mental or nervous disorder” shall no be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

E. “Skilled nursing care”, “intermediate care”, “personal care”, “home care”, and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

F. All providers of services, including but not limited to “skilled nursing facility”, “extended care facility”, “intermediate care facility”, “convalescent nursing home”, “personal care facility”, and “home care agency” shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Rule 8.06: Disclosure and Performance Standards for Long-Term Care Insurance

A. No long-term care insurance policy may:

1. Be cancelled, non-renewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insuredindividual or certificateholder; or

2. Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

3. Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lowerlevels of care.

B. Pre-existing condition:

1. No long-term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in Section 4E(1) of this Regulation shall use a definition of "preexisting condition" which is more restrictive than the following: Preexisting condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six (6) months preceding the effective date of coverage of an insured person.

2. No long-term care insurance policy or certificate other than a policy orcertificate thereunder issued to a group as defined in Section 4E(1) mayexclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six (6) months following the effective date of coverage of an insured person.

3. The Commissioner may extend the limitation periods set forth in Sections 6B (1) and (2) above as to specific age group categories in specific policy forms upon findings that the extension is in the best interest of the public.

4. The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in Section 6B(2) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting

diseases or physical conditions beyond the waiting period described in Section 6B(2).

C. Prior hospitalization/institutionalization:

1. No long-term care insurance policy may be delivered or issued for delivery in the State if such policy:

    a. Conditions eligibility for benefits on a prior hospitalizationrequirement;

    b. Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

    c. Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperativebenefits on a prior institutionalization requirement.

2. a. A long-term care insurance policy containing post-confinement, post acute care or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement.

    A long-term care insurance policy or rider which conditions eligibility of non-institutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty (30) days.

D. Right to return-free look:

Long-term care insurance applicants 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 applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant 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, other than a certificate issued pursuant to a policy issued to a group defined under Section 4(E)1 of the Regulation, the applicant is not satisfied for any reason.

E. 1. An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

a. In the case of agent solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

b. In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

2. The outline of coverage shall include:

a. A description of the principal benefits and coverage provided in the policy;

b. A statement of the principal exclusions, reductions, and limitationscontained in the policy;

c. A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including anyreservation in the policy of a right to change premium. Continuation or conversation provisions of group coverage shall be specifically described.

d. A statement that the outline of coverage is a summary only, nota contract of insurance, and that the policy or group master policycontain governing contractual provisions;

e. A description of the terms under which the policy or certificate may be returned and premium refunded; and

f. A brief description of the relationship of cost of care and benefits.

F. A certificate issued pursuant to a group long-term insurance policy which policy is delivered or issued for delivery in this state shall include:

1. A description of the principal benefits and coverage provided in the policy.

2. A statement of the principal exclusions, reductions and limitations contained in the policy; and

3. A statement that the group master policy determines governing contractual provisions.

G. At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at

the time of policy delivery, In addition to complying with all applicable requirements, the summary shall also include:

1. An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;
2. An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, if any, for each covered person:
3. Any exclusions, reductions and limitations on benefits of long-term care: and
4. If applicable to the policy type, the summary shall also include:
    a. A disclosure of the effects of exercising other rights under the policy;
    b. A disclosure of guarantees related to long-term care cost of insurance charges; and
    c. Current and projected maximum lifetime benefits.

H. Any time a long-term care benefit, funded through a life insurance vehicle bythe acceleration of the death benefit, is in benefit payment status, a monthlyreport shall be provided to the policyholder. Such report shall include:

1. Any long-term care benefits paid out during the month;
2. An explanation of any changes in the policy, e.g. death benefits or cashvalues, due to long-term care benefits being paid out; and
3. The amount of long-term care benefits existing or remaining.

I. .Any policy or rider advertised, marketed or offered as long-term care or nursing home insurance shall comply with the provisions of this Regulation.

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Rule 8.07: Policy Practices and Provisions

A. Renewability. The terms “guaranteed renewable” and “noncancellable” shall not be used in any individual long-term care insurance policy without further explanatorylanguage in accordance with the disclosure requirements of Section 8 of this Regulation.

1. No such policy issued to an individual shall contain renewal provisions lessfavorable to the insured than “guaranteed renewable”. However, the Commissioner may authorize nonrenewal on a statewide basis, on terms and

conditions deemed necessary by the Commissioner, to best protect the interests of the insureds, if the insurer demonstrates:

a. That renewal will jeopardize the insurer's solvency; or

b. That:

i. The actual paid claims and expenses have substantially exceeded thepremium and investment income associated with the policies; and

ii. The policies will continue to experience substantial and unexpectedlosses over their lifetime; and

iii. The projected loss experience of the policies cannot be significantlyimproved or mitigated through reasonable rate adjustments or otherreasonable methods; and

iv. The insurer has made repeated and good faith attempts to stabilize lossexperience of the policies, including the timely filing for rate adjustments.

2. The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

3. The term "noncancellable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

B. Limitations and Exclusions. No policy may be delivered or issued for delivery inthis state as long-term care insurance if such policy limits or excludes coverage bytype of illness, treatment, medical condition or accident, except as follows:

1. Preexisting conditions or diseases;

2. Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease;

3. Alcoholism and drug addiction;

4. Illness, treatment or medical condition arising out of:

a. War or act of war (whether declared or undeclared);

b. Participation in a felony, riot or insurrection;

c. Service in the armed forces or units auxiliary thereto;

d. Suicide (sane or insane), attempted suicide or intentionallyself-inflicted injury; or

e. Aviation (this exclusion applies only to non-fare-paying passengers).

5. Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.

6. This Subsection B is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

C. Extension of Benefits. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continueswithout interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited tothe duration of the benefit period, if any, or to payment of the maximum benefitsand may be subject to any policy waiting period, and all other applicable provisions of the policy.

D. Continuation or Conversion.

1. Group long-term care insurance issued in this state on or after the effective date of this section shall provide covered individuals with a basis for continuation or conversion of coverage.

2. For the purposes of this section, "a basis for continuation of coverage" means a policy provision which maintains coverage under the existinggroup policy when such coverage would otherwise terminate and whichis subject only to the continued timely payment of premium when due.Group policies which restrict provision of benefits and services to, orcontain incentives to use certain providers and/or facilities may provide continuation benefits which are substantially equivalent of benefits, and in doing so, shall take into consideration the differences between managed care and non-managed care plans, including, but not

limited to, providersystem arrangements, service availability, benefit levels and administrative complexity.

3. For the purposes of this section, "a basis for conversion of coverage" means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class; and who has been continuously insuredunder the group policy (and any group policy which it replaced), for atleast six months immediately prior to termination, shall be entitled to theissuance of a converted policy by the insurer under whose group policy heor she is covered, without evidence of insurability.

4. For the purposes of this section, "converted policy" means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use certain providers and / or facilities, the Commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

5. Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than thirty-one (31) days after termination of coverage under the group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

6. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which the conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

7. Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

   a. Termination of group coverage resulted from an individual'sfailure to make any required payment of premium or contribution when due; or

   b. The terminating coverage is replaced not later than thirty-one (31) days after termination, by group coverage effective on the

day following the termination of coverage:

i. Providing benefits identical to or benefits determined by the Commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage; and

ii. The premium for which is calculated in a manner consistent with the requirements of Paragraph (6) of this section.

8. Notwithstanding any other provision of this section, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

9. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

10. Notwithstanding any other provision of this section, any insured individual whose eligibility for group long-term care coverage is based upon his or her relationship to another person, shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

11. For the purposes of this section: A "Managed-Care Plan" is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Rule 8.08: Required Disclosure Provisions

A. Renewability. Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for whichthe policy is issued and for which it may be renewed. This provision shall notapply to policies which do not contain a renewability provision, and under whichthe right to non-renew is reserved solely to the policyholder.

B. Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by law. Where a separate additional premium is charge for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

C. Payment of benefits: A long-term care insurance policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

D. Limitations. If a long-term care insurance policy or certificate contains anylimitations with respect to preexisting conditions, such limitations shall appear asa separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

E. Other Limitations or Conditions on Eligibility for Benefits. A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in Section 6C(2) of the Regulation shall set forth a description of such limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Rule 8.09: Prohibition against Post-Claims Underwriting

A. All applications for long-term care insurance policies or certificates except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

B. 1. If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

   2. If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical

condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

C. Except for policies or certificates which are guaranteed issue:

1. The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate.

   Caution: If your answers on this application are incorrect or untrue, (company) has the right to deny benefits or rescind your policy.

2. The following language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

   Caution: The issuance of this long-term care insurance (policy) (certificate) is based upon your responses to the questions on your application. A copy of your (application) (enrollment form)(is enclosed)(was retained by you when you applied). If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: (insert address).

3. Prior to issuance of a long-term care policy or certificate to applicantageeighty (80) or older, the insurer shall obtain one of the following:

   a. A report of a physical examination;

   b. An assessment of functional capacity;

   c. An attending physician's statement; or

   d. Copies of medical records.

D. A copy of the completed application or enrollment form (whichever isapplicable) shall be delivered to the insured no later than at the time ofdelivery of the policy or certificate unless it was retained by the applicant at the time of application.

E. Every insurer or other entity selling or issuing long-term care insurancebenefits shall maintain a record of all policy or certificate rescissions, bothstate and countrywide, except those which the insured voluntarilyeffectuated and shall annually furnish this information to the InsuranceCommissioner in the format prescribed by the National Association of Insurance Commissioners.

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Rule 8.10: Minimum Standards for Home Health Care Benefits in Long-Term Care Insurance Policies

A. A long-term care insurance policy or certificate may not, if it provides benefits for home health care services, limit or exclude benefits:

1. By requiring that the insured/claimant would need skilled care in a skilled nursing facility if home health care services not provided;

2. By requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic services in a home or community setting before home health care services are covered;

3. By limiting eligible services to services provided by registered nurses or licensed practical nurses;

4. By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of his or her licensure or certification;

5. By requiring that the insured/claimant have an acute condition before home health care services are covered;

6. By limiting benefits to services provided by Medicare-certified agencies or providers.

B. Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Rule 8.11: Requirement to Offer Inflation Protection

A. No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the cost of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

1. Increases benefit levels annually, (in a manner so that the increases are compounded annually);

2. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined; or

3. Covers a specified percentage of actual or reasonable charges.

B. Where the policy is issued to a group, the required offer in Subsection A above shall be made to the group policyholder; except, if the policy is issued to a group defined in Section 4E(4) of this Regulation, other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

C. The offer in Subsection A above shall no be required of:

1. Life insurance policies or riders containing accelerated long-term care benefits, nor

2. Expense incurred long-term care insurance policies.

D. Insurers shall include the following information in or with the outline of coverage:

1. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a twenty (20) year period.

2. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases.

3. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Rule 8.12: Requirements for Replacement

A. Question Concerning Replacement. Individual and direct response solicited long-term care insurance application forms shall include a question designed to elicit information as to whether the proposed insurance policy is intended to replace any other accident and sickness or long-term care insurance policy presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

B. Solicitations Other than Direct Response. Upon determining that a sale will involve replacement, an insurer; other than an insurer using direct response solicitation methods, or its agent; shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by (company name) Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protections, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, 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 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, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

____

(date)

____

(Applicant's Signature)

C. Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by (company name) Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. (To be included only if the application is attached to the policy.)

   If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (company name and address) within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out of the application.

____
(Company Name)

Source: *Miss Code Ann* §§83-5-1; 83-5-29 (Rev. 2011)

Rule 8.13: Discretionary Powers of Commissioner

The Commissioner may upon written request and after an administrative hearing, issue an order to modify or suspend a specific provision or provisions of this regulation with respect to a specific long-term care insurance policy or certificate upon a written finding that:

A. The modification or suspension would be in the best interest of the insureds; and

B. The purposes to be achieved could not be effectively or efficiently achieved without the modification or suspension; and

C.
1. The modification or suspension is necessary to the development of an innovative and reasonable approach for insuring long-term care; or

2. The policy or certificate is to be issued to residents of a life care or continuing care retirement community or some other residential community for the elderly and the modification or suspension is reasonably related to the special needs or nature of such a community; or

3. The modification or suspension is necessary to permit long-term care insurance to be sold as part of, or in conjunction with, another insurance project.

Source: *Miss Code Ann* § 83-5-1 (Rev. 2011)

Rule 8.14: Reserve Standards

A. When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for such benefits shall be determined in accordance with Miss Code Ann. Section 83-7-23 (1972), as Amended. Claim reserves must also be established in the case when such policy or rider is in claim status.

B. Reserves for policies and riders subject to this subsection should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

In the development and calculation of reserves for policies and riders subject to this subsection, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

1. Definition of insured events;

2. Covered long-term care facilities;

3. Existence of home convalescence-care coverage;

4. Definition of facilities;

5. Existence or absence of barriers to eligibility;

6. Premium waiver provision;

7. Renewability;

8. Ability to raise premiums;

9. Marketing methods;

10. Underwriting procedures;

11. Claims adjustment procedures;

12. Waiting period;

13. Maximum benefit;

14. Availability of eligible facilities;

15. Margin in claim cost;

16. Optional nature of benefit;

17. Delay in eligibility for benefit;

18. Inflation protection provisions; and

19. Guaranteed insurability option.

Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

C. When long-term care benefits are provided other than as in Subsection A above, reserves shall be determined in accordance with standards adopted by the National Association ofInsurance Commissioners.

Source: *Miss Code Ann* §83-7-23 (Rev. 2011)

Rule 8.15: Loss Ratio

Benefits under individual long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent, calculated in a

manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

A. Statistical credibility of incurred claims experience and earned premiums;

B. The period for which rates are computed to provide coverage;

C. Experienced and projected trends;

D. Concentration of experience within early policy duration;

E. Expected claim fluctuation;

F. Experience refunds, adjustments or dividends;

G. Renewability features;

H. All appropriate expense factors;

I. Interest;

J. Experimental nature of coverage;

K. Policy reserves;

L. Mix of business by risk classification; and

M. Product features such as long elimination periods, high deductibles and high maximum limits.

Source: *Miss Code Ann* §§83-5-1; 83-5-29 (Rev. 2011)

Rule 8.16: Filing Requirement

Prior to an insurer or similar organization offering group long-term care insurance to a resident of this state, it shall file with the Commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

Source: *Miss Code Ann* §§83-5-1; 83-9-5(7) (Rev. 2011)

Rule 8.17: Standard Format Outline of Coverage

This section of the Regulation implements, interprets and makes specific, the provisions of Section 6E of this Regulation, in prescribing a standard format and the content of an outline of coverage.

A. The outline of coverage shall be a free-standing document, using no smaller than ten-point type.

B. The outline of coverage shall contain no material of an advertising nature.

C. Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

D. Use of the text and sequence of text of the standard format outline of coverageis mandatory, unless otherwise specifically indicated.

E. Format for outline of coverage:

(Company Name)

(Address-City & State)

(Telephone Number)

Long-Term Care Insurance

Outline of Coverage

(Policy Number or Group Master Policy and Certificate Number)

(Except for policies or certificates which are guaranteed issue, the following caution statement, or language substantially similar, must appear as follows in the outline of coverage.)

Caution: The issuance of this long-term care insurance (policy) (certificate) is based upon your responses to the questions on your application. A copy of your (application) (enrollment form) (is enclosed) (was retained by you when you applied). If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: (insert address)

1. This policy is (an individual policy of insurance)[(a group policy) which was issued in the (indicate jurisdiction in which group policy was issued)].

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an

insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) (Provide a brief description of the right to return—"free look" provision of the policy.)

(b) (Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.)

4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) (For agents) Neither (inset company name) nor its agents represent Medicare, the federal government or any state government.

(b) (For direct response) (insert company name) is not representing Medicare, the federal government or any state government.

5. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy (limitations) (waiting periods) and (coinsurance) requirements. (Modify this paragraph if the policy is not an indemnity policy.)

6. BENEFTIS PROVIDED BY THIS POLICY.

(a) (Covered services, related deductibles(s), waiting periods, elimination periods and benefit maximums.)

(b) (Institutional benefits, by skill level.)

(c) (Non-institutional benefits, by skill level.)

(Any benefit screens must be explained in this section. If these screens differ for different benefits, explanation of the screen should accompany each benefit description. If an attending physician or other specified person must certify a certain level of functional dependency in order to be eligible for benefits, this too must be specified. If activities of daily living (ADLs) are used to measure an insured's need for long-term care, then these qualifying criteria or screens must be explained.)

7. LIMITATIONS AND EXCLUSIONS.

(Describe:

(a) Preexisting conditions;

(b) Non-eligible facilities/provider;

(c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions/exceptions;

(e) Limitations.)

(This section should provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of benefits described in (6) above.)

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

8. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the cost of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. (As applicable, indicate the following:

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations:

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.)

9. TERMS UNDER WHICH THE POLICY (OR CERTIFICATE) MAY BE CONTINUED IN FORCE OR DISCONTINUED.

[(a) Describe the policy renewability provisions:

(b) For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;

(c) Describe waiver of premium provisions or state that there are not such provisions;

(d) State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which premium may change.]

10. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

(State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.)

11. PREMIUM.

[(a) State the total annual premium for the policy;

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

12. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

Source: *Miss Code Ann* §§83-5-1; 83-9-5 (Rev. 2011)

Rule 8.18: Requirement to Deliver Shopper's Guide

A. A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the Commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

1. In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

2. In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

B. Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under Section 6 of this Regulation.

Source: *Miss Code Ann* §83-5-1 (Rev. 2011)

Rule 8.19: Effective Date

This regulation shall become effective thirty (30) days after its adoption and filing with the Mississippi Secretary of State's Office, as required by law.

Source: *Miss code Ann* §25-43-3.113 (Rev. 2010)

Part 3Chapter 9: (94-101) Requiring Notification of Coverage Offered by Comprehensive Health Insurance Risk Pool Association Upon Rejection of Application for Coverage.

Rule 9.01: Authority

This Regulation is promulgated by the Commissioner of Insurance pursuant to the authority granted to him by *Miss. Code Ann*. § 83-5-1 and 83-9-211 (1972), in order to implement the provisions of the Comprehensive Health Insurance Risk Pool Association Act and is promulgated in accordance with Mississippi Insurance Department Regulation No. 88-101, said regulation being the Rules of Practice and Procedure before the Mississippi Insurance Department.

Source: *Miss Code Ann* §§83-5-1; 83-9-211 (Rev. 2011)

Rule 9.02: Purpose

The purpose of this Regulation is to implement the intent of the Mississippi Legislature with respect to making the existence of the insurance plan offered by the Comprehensive Health Insurance Risk Pool Association known to those citizens of the State of Mississippi who, because of health conditions, cannot secure health insurance coverage by requiring insurers to notify persons that are rejected for health insurance coverage because of health conditions that such persons may be eligible for the insurance plan offered by the Comprehensive Health Insurance Risk Pool Association and to establish a standardized form for such notice.

Source: *Miss Code Ann* §83-9-203 (Rev. 2011)

Rule 9.03: Definitions

A. "Health insurance" shall have the same meaning as defined in Miss. Code Ann.§ 83-9-205 (1972).

B. "Insurer" shall have the same meaning as defined in Miss. Code Ann.§ 83-9-205(1972).

Source: *Miss Code Ann* §83-9-205 (Rev. 2011)

Rule 9.04: Application

Any insurer that rejects a person's application for health insurance coverage substantially similar to the coverage offered by the Comprehensive Health Insurance Risk Pool Association because of health conditions of such person shall give such person written notice that he or she may be eligible for coverage under the Comprehensive Health Insurance Risk Pool Associationplan and furnish the name, address and toll free telephone number of the Comprehensive Health Insurance Risk Pool Association.

Such notice shall be in the form attached hereto as appendix A, which is hereby made a part of this Regulation. Insurers may print the notice form on their own stationary but shall use the order, format and content of the notice form, as prescribed by the Commissioner of Insurance. The insurer shall attach a copy of the notice form to the notice of rejection for insurance coverage.

Source: *Miss Code Ann* §83-9-215 (Rev. 2011)

Rule 9.05: Severability

If any provision of any section of this Regulation or the application thereof to any circumstance or person or entity is held invalid, such invalidity shall not affect any other provision of that section or application of the Regulation which can be given effect without the invalid provision or application, and to this end the provisions of this Regulation are declared to be severable.

Source: *Miss Code Ann* §§83-5-1; 83-9-215 (Rev. 2011)

Rule 9.06: Effective Date

This Regulation shall become effective immediately upon filing with the Office of the Secretary of State.

Source: *Miss Code Ann* §25-43-3.113 (Rev. 2010)

Rule 9.07: Appendix A- Comprehensive Health Insurance Risk Pool Association Notice Form

APPENDIX A

Comprehensive Health Insurance Risk Pool Association
Notice Form

Date

Name
Address
City, State Zip Code

RE: Applicant/Insured's Name
Policy # (if applicable)

Dear ___________________:

We believe that you may qualify for health insurance from the Mississippi Comprehensive Health Insurance Risk Pool Association (the "Association"). This insurance is available to Mississippi residents who, because of health conditions, cannot secure health insurance coverage substantially similar to the Association plan coverage without material underwriting restrictions at a rate equal to or less than the Association plan rate. Other eligibility requirements, exclusions and limitations may apply.

You may apply to the Association for a determination of your eligibility for insurance on application forms available from the Association.

For more information regarding the Association go to www.mississippihealthpool.org or contact the Association at:

Mississippi Comprehensive Health Insurance Risk Pool Association
Post Office Box 13748
Jackson, MS 39236-3748
888-820-9400

Insurance Company Name
Address

Contact Person
Phone Number

Source: *Miss Code Ann* §83-9-215 (Rev. 2011)

Part 3 Chapter 10: (96-103) Regulation to Implement The Medicare Supplement Insurance Minimum Standards Model Act, as amended, Effective 6/30/2009**.**

Rule 10.01. 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; tofacilitate 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.

Source: *Miss Code Ann* §83-9-103 (Rev. 2011)

Rule 10.02 Authority

This regulation is issued pursuant to the authority vested in the commissioner under Miss. Code Ann. §83-9-103 and §83-9-105.

Editor's Note: Wherever the term "commissioner" appears, the title of the chief insurance regulatory official of the state should be inserted.

Source: *Miss Code Ann* §§83-9-103; 83-9-105 (Rev. 2011)

Rule 10.03 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.

Source: *Miss Code Ann* §§83-9-102; 83-9-103 (Rev. 2011)

Rule 10.04 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. 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 of Title 10 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;

h. A health plan offered under chapter 89 of Title 5 United States Code (Federal EmployeesHealth Benefits Program);

i. A public health plan as defined in federal regulation; and

j. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 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 thereof;

   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 of title 10, 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, and as further defined in Miss. Code Ann. § 83-24-7(k).

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. § 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. “Medicare supplement policy” does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under §1833(a)(1)(A) of the Social Security Act.

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 July 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 July 1, 1992 and with an effective date for coverage prior to June 1, 2010.

O. “2010 Standardized Medicare supplement benefit plan," "2010 Standardized benefit plan" or "2010 plan" means a group or individual policy of Medicare supplement insurance 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.

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

Rule 10.05: 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 which 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.

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

Rule 10.06: 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.

Source: Miss Code Ann §83-9-103(Rev. 2011)

Rule 10.07: Minimum Benefit Standards ForPre-Standardized Medicare SupplementBenefit Plan Policies Or Certificates Issued For Delivery Prior To July 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, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

4. A "non-cancellable," "guaranteed renewable," or "non-cancellable 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 non-renewed by the issuer solely on the grounds of deterioration of health.

5.
   a. Except as authorized by the commissioner of this state, an issuer shall neither cancel nor non-renew 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 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.

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

Rule 10.08: Benefit Standards For 1990 Standardized Medicare Supplement Benefit Plan Policies Or Certificates Issued For Delivery After July 1, 1992 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 July 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, co-payment, 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 non-renew the policy solely on the ground of health status of the individual.

    b. The issuer shall not cancel or non-renew 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 (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within 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 [commissioner] if the insured replaces a [1990 Standardized] policy or certificate with an issue age rated [2010 Standardized] policy or certificate at the insured's original issue age [and duration]. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the commissioner according to the state's rate filing procedure.

   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 pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged [1990 Standardized] policy or certificate of the insured, but may apply pre-existing condition limitations of no more than six (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 co-payment 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 allof 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 charge 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 charge 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 nurse’s 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:

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

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

(c) $1,600 per calendar year;

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

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

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

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

(h) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (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 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. 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.

10.08.1: 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 delivery on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any [1990 Standardized Medicare supplement benefit plan] for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage prior to June 1, 2010 remain subject to the requirements of Miss. Code Ann. § 83-9-101 to 115, and Regulation 96-103, as amended (effective March 25, 2005).

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, co-payment, 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 non-renew the policy solely on the ground of health status of the individual.

   b. The issuer shall not cancel or non-renew 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 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 8.1A(5)(c) of this regulation; 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.

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 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.

    a. If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within 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.

    b. 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.

    c. 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 certificate holder as the premium

classification terms that would have applied to the policyholder or certificate holder 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 co-payment 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.

   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.

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

Rule 10.09: Standard Medicare Supplement Benefit Plans For 1990 Standardized Medicare Supplement Benefit Plan Policies Or Certificates Issued For Delivery After July 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 certificate holder 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.

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.

E. 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 8 D(1).

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

F. New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner 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.

10.09.1: Standard Medicare Supplement Benefit Plans for 2010 Standardized Supplement Benefit Plan Policies or Certificates Issued for Delivery 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 with an effective date for coverage before June 1, 2010 remain subject to the requirements of Miss. Code Ann. § 83-9-101 to 115, and Regulation 96-103, as amended (effective March 25, 2005).

A. 1. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in 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 certificate holder, 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 an 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.

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 co-payments in the following amounts:

a. the lesser of twenty dollars ($20) or the Medicare Part B coinsurance or co-payment 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 co-payment for each covered emergency room visit, however, this co-payment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

New or Innovative Benefits: An issuer may, with the prior approval of the [commissioner], offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

Rule 10.10: Medicare Select Policies AndCertificates

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 commissioner within which an issuer is authorized to offer a Medicare Select policy.

C. The commissioner 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 commissioner 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 commissioner.

E. 1. A Medicare Select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

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

   i. 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.

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

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

      (b) To make appropriate referrals.

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

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

   v. 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.

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

c. A description of the grievance procedure to be utilized.

d. A description of the quality assurance program, including:

   i. The formal organizational structure;

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

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

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

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

g. Any other information requested by the commissioner.

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 commissioner prior to implementing the changes. Changes shall be considered approved by the commissioner after thirty (30) days unless specifically disapproved.

2. An updated list of network providers shall be filed with the commissioner 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 commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

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 requiringevidence 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.

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

Rule 10.11: 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 latter of the first day:
    1. of the first month in which an individual is enrolled for benefits under Medicare Part B, or
    2. in the event of retroactive approval by Medicare, the date of approval. 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.

D. This section applies to a person who qualified for Medicare by reason of disability and who obtains a Medicare Supplement policy during the six month period described in subsection (A) of this rule. Persons eligible for disability by reasonof disability before age 65 who are enrolled in a managed care plan and whose coverage under the managed care plan is terminated through cancellation, nonrenewal, or disenrollment have the guaranteed right to purchase Medicare Supplements Plans A, B, C, or F from any insurer within 63 days after the date of termination or disenrollment. An insurer may develop premium rates specific to the disabled population. The rates and any applicable rating factors for the Medicare Supplement plans referred to in this section shall be filed with and approved by the Commissioner.

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

Rule 10.12: Guaranteed Issue ForEligible Persons

A. Guaranteed Issue.

1. Eligible persons are those individuals described in Subsection B who seek to enroll under the policy not later than sixty-three (63) days after the date of termination of enrollment described in subsection B, 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, or the organization or plan has notified the individual of an impending termination of such certification;

    b. The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuation of such plan;

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

5. 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); or

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 working days of the issuer receiving notification of disenrollment.

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

Rule 10.13: Standards ForClaims 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.

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

Rule 10.14: Loss Ratio Standards AndRefund 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.

   For policies issued prior to July 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 April 26, 1996 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 commissioner by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

   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 July 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 26, 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 Mississippi Insurance Department Regulation 96-103, As Amended, in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. 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 commissioner, 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 commissioner, the commissioner 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 commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of Mississippi Insurance Regulation 96-103, As Amended, 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 commissioner.

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

Rule 10.15: Filing AndApproval 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 commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

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 commissioner in the state in which the policy or certificate was issued.

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

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 commissioner, 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 commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

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

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 commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner 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 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 commissioner, 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 commissioner 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 of this regulation.

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.

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

Rule 10.16: 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.

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

Rule 10.17: 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 commissioner. 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 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.

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

Basic Benefits:

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

A	B	C	D	*	G	K	L	M	N
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	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
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% 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	50% Part A Deductible	75% Part A Deductible	50% 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 [$2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $[4620]; paid at 100% after limit reached	Out-of-pocket limit $[2310]; paid at 100% after limit reached		

PREMIUM INFORMATION [Boldface Type]

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

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

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

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

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

RIGHT TO RETURN POLICY [Boldface Type]

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

POLICY REPLACEMENT [Boldface Type]

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

NOTICE [Boldface Type]

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

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

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

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *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 commissioner.]

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$0	$[1068](Part A deductible)
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	$0	Up to $[133.50] a day
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 $[135] (Part B deductible) $0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs

BLOOD First 3 pints Next $[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 $[135] (Part B deductible) $0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068](Part A deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used:	$0	100% of Medicare eligible expenses	$0**
—Additional 365 days		$0	All costs
—Beyond the additional 365 days	$0		
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	$0	Up to $[133.50] a day
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY

BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	 All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	 Medicare co-payment/ coinsurance	 $0

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, F			
First $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0
Next $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[135] of Medicare Approved Amounts*	$0	$[135](Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068](Part A deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0 $0**
—Once lifetime reserve days are used:	$0	100% of Medicare eligible expenses	All costs
Additional 365 days —Beyond the additional 365 days	$0	$0	
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	 All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	 Medicare co-payment/ coinsurance	 $0

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare Approved Amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0
Next $[135] of Medicare Approved Amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $[135] of Medicare Approved Amounts*	$0	$[135](Part B deductible)	$0
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 maxi-mum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068] (Part A deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day $0	$0
—Once lifetime reserve days are used:		100% of Medicare eligible expenses	$0**
Additional 365 days	$0	$0	All costs
—Beyond the additional 365 days	$0		
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	 All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	 Medicare co-payment/ coinsurance	 $0

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

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 $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

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 maxi-mum 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 [$2000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]**

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $[1068]	$[1068] (Part A deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 Lifetime reserve days	All but $[534] a day	$[534] a day	$0
Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare eligible expenses	$0***
Beyond the additional 365 days	$0	$0	All costs

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	$0

(continued)

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

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

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, Such as physician's Services, inpatient and Outpatient medical and Surgical services and Supplies, physical and Speech therapy, Diagnostic tests, Durable medical Equipment,			
First $[135] of Medicare Approved amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare Approved amounts	Generally 80%	Generally 20%	$0

Part B excess charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $[135] of Medicare Approved amounts* Remainder of Medicare Approved amounts	 $0 $0 80%	 All costs $[135] (Part B deductible) 20%	 $0 $0 $0

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2000] DEDUCTIBLE, **] PLAN PAYS	[IN ADDITION TO $[2000] DEDUCTIBLE, **] YOU PAY
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 $[2000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[2000] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $[135] of Medicare Approved Amounts*	$0	$[135] (Part B deductible)	$0
Remainder of Medicare — Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[2000] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[2000] DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary Emergency care services Beginning during the first 60 days of each trip outside the USA First $250 each calendar year	 $0	 $0	 $250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068] (Part A deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ 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

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

* Once you have been billed $[133.50] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints	$0	All costs	$0
Next $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN G

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 $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $[1068]	$[534](50% of Part A deductible)	$[534](50% of Part A deductible)♦
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital			
First 20 days	All approved amounts.	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[66.75] a day	Up to $[66.75] a day ♦
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	50%	50%♦
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	50% of co-payment/ coinsurance	50% of Medicare co-payment/coinsurance ♦

(continued)

*** **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.

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $[135] of Medicare Approved Amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	$0 Generally 75% or more of Medicare approved amounts Generally 80%	$0 Remainder of Medicare approved amounts Generally 10%	$[135] (Part B deductible)**** ♦ All costs above Medicare approved amounts Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$4620])*
BLOOD First 3 pints Next $[135] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	$0 $0 Generally 80%	50% $0 Generally 10%	50%♦ $[135] (Part B deductible)**** ♦ Generally 10% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

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

PLAN K

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $[135] of Medicare Approved Amounts*****	$0	$0	$[135] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	10%	10%♦

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

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[2310] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare 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*
BLOOD First 3 pints Additional amounts	 $0 100%	 75% $0	 25%♦ $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	 All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	 75% of co-payment/ coinsurance	 25% of co-payment/ coinsurance ♦

(continued)

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $[135] of Medicare Approved Amounts****	$0	$0	$[135] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$2310])*
BLOOD			
First 3 pints	$0	75%	25%♦
Next $[135] of Medicare Approved Amounts****	$0	$0	$[135] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦

CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

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

PLAN L

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[135] of Medicare Approved Amounts*****	$0	$0	$[135] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	15%	5% ♦

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

PLAN M

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[534](50% of Part A deductible)	$[534](50% of Part A deductible)
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[133.50] a day	Up to $[133.50] a day	$0
101st day and after	$0	$0	All costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ 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 $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment —First $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0
Next $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
OME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $[135] of Medicare Approved Amounts*	$0	$0	$[135](PartB 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 maxi-mum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1068]	$[1068](Part A deductible)	$0
61st thru 90th day	All but $[267] a day	$[267] a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $[534] a day	$[534] a day	$0
—Once lifetime reserve days are used: —Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs

SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	 All approved amounts All but $[133.50] a day $0	 $0 Up to $[133.50] a day $0	 $0 $0 All costs
BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ 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 $[135] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[135] of Medicare Approved Amounts*	$0	$0	$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs

BLOOD First 3 pints Next $[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 $[135] (Part B deductible) $0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies —Durable medical equipment First $[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $[135] (Part B deductible) $0

OTHER BENEFITS—NOT COVERED BY MEDICARE

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. § 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.

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

Rule 10.18: 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 REPLACMENT
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 pre-existing 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.

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

Rule 10.19: Filing Requirements ForAdvertising

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

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

Rule 10.20: Standards ForMarketing

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 Miss. Code Ann. § 83-5-29, *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.

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

Rule 10.21: Appropriateness OfRecommended 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

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

Rule 10.22: 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.

Editor's Note: Appendix B contains a reporting form for compliance with this section.

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

Rule 10.23: Prohibition AgainstPreexisting 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 for similar benefits 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 for benefits similar to those contained in the original policy or certificate.

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

Rule 10.24: 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 pre-existing 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 orcertificate 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 pre-existing 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.

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

Rule 10.25: Separability

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

Source: *Miss Code Ann* §83-9-115(Rev. 2011)

Rule 10.26: Effective Date

This regulation shall be effective on June 30, 2009.

Source: *Miss code Ann* §25-43-3.113(Rev. 2010)

Rule 10.27: Appendix A- Reporting Form for Calculation of Loss Ratios

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 Completing Exhibit ______________________
Title ______________________ Telephone Number ______________________

Line		(a) Earned Premium[3]	(b) Incurred Claims[4]
1.	Current Year's 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)		

Line		
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.	

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 Includes 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"

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 Completing Exhibit ______________________
Title ______________________ Telephone Number ______________________

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)]	

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

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 Completing 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__________

TYPE[1] __________ SMSBP[2] __________
For the State of __________ Company Name __________
NAIC Group Code __________ NAIC Company Code __________
Address __________ Person Completing 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.

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.

Source: *Miss code Ann* §83-9-107(Rev. 2011)

Rule 10.28: Appendix B- Form for Reporting Duplicate Policies

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

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

Rule 10.29: Disclosure Statements 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.

Source: *Miss Code Ann* §83-9-103(Rev. 2011)

Chapter 11: (98-1) Heath Care Professional Credentialing Verification (As Amended).

Rule 11.01: Authority

This Regulation is promulgated pursuant to the authority vested in the Commissioner of Insurance under Article 7 and Article 9 of Chapter 41 of Title 83 of the Mississippi Code of 1972, Annotated, and is promulgated in accordance with Mississippi Insurance Department Regulation No. 88-101, being the Rules of Practice and Procedure Before the Mississippi Insurance Department.

Source: *Miss Code Ann* §§83-5-1; 83-41-413 (Rev. 2011)

Rule 11.02: Purpose and Intent

This Regulation requires a managed care entity to establish a comprehensive health care professional credentialing verification program to ensure that its participating health care professionals meet specific minimum standards of professional qualification. The standards set out in this Regulation address the initial credentialing verification and subsequent recredentialing process

Source: *Miss Code Ann* §§83-5-1; 83-41-413 (Rev. 2011)

Rule 11.03: Definitions

For purposes of this Regulation:

A. "Commissioner" means the Commissioner of Insurance.

B. "Credentialing verification" is the process of obtaining and verifying information about a health care professional, and evaluating the professional credentials of that health care professional, when that health care professional applies to become a participating provider in a managed care plan offered by a managed care entity.

C. "Health care professional" means a physician or other health care practitioner licensed or certified by the state to perform specified health services.

D. "Health care services" or "health services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

E. "Managed care contractor" means a person or corporation that:

   1. Establishes, operates or maintains a network of participating providers;

   2. Conducts or arranges for utilization review activities; and

   3. Contracts with an insurance company, a hospital or medical service plan, an employer or employee organization, or any other entity providing coverage for health care services to operate a managed care plan.

F. "Managed care entity" means a licensed insurance company, hospital or medical service plan, health maintenance organization (HMO), an employer or employee organization, or a managed care contractor as defined under G. above, that operates a managed care plan.

G. "Managed care plan" means a plan operated by a managed care entity that provides for the financing and delivery of health care services to persons enrolled in such plan through:

1. Arrangements with selected providers to furnish health care services;

2. Explicit standards for the selection of participating providers;

3. Organizational arrangements for ongoing quality assurance, utilizationreview programs and dispute resolution; and

4. Financial incentives for persons enrolled in the plan to use the participating providers, products and procedures provided for by the plan.

"Participating provider" means a health care professional licensed or certified by the state, that has entered into an agreement with a managed care entity to provide health care services, products or supplies to a patient enrolled in a managed care plan.

H. "Physician" means one who is educated and trained to practice the art and scienceof medicine and who has received the degree of doctor of medicine or osteopathyfrom an accredited and recognized school or college of medicine or osteopathicmedicine.

I. "Primary verification" means verification by the managed care entity of a healthcare professional's credentials based upon evidence obtained from the issuingsource of the credential.

J. "Secondary verification" means verification by the managed care entity of a health care professional's credentials based upon evidence obtained by meansother than direct contact with the issuing source of the credential (e.g., copies of certificates provided by the applying health care professional).

Source: Miss Code Ann §§83-5-1; 83-41-413 (Rev. 2011)

Rule 11.04: Applicability AndScope

This Regulation shall apply to managed care entities that offer, operate or participate in managed care plans.

Source: *Miss Code Ann* §§83-5-1; 83-41-413 (Rev. 2011)

Rule 11.05: General Responsibilities Of The Managed Care Entity

A. A managed care entity shall:

1. Establish written policies and procedures for credentialing verification of all health care professionals with whom the managed care entity contractsand apply these standards consistently;

2. Verify the credentials of a health care professional when entering into a contract with that health care professional. The medical director of the managed care entity or other designated health care professional shall have responsibility for, and shall participate in, health care professionalcredentialing verification;

3. Establish a credentialing verification committee consisting of licensedphysicians and other health care professionals to review credentialingverification information and supporting documents and make decisionsregarding credentialing verification;

4. Make available for review by the applying health care professional upon written request all application and credentialing verification policies and procedures; and

5. Keep confidential all information obtained in the credentialingverificationprocess, except as otherwise provided by law.

B. Nothing in this regulation shall be construed to require a managed care entity to select a provider as a participating provider solely because the provider meets the managed care entity's credentialing verification standards, or to prevent a managed care entity from utilizing separate or additional criteria in selecting the health care professionals with whom it contracts.

Source: *Miss Code Ann* §§83-5-1; 83-41-413 (Rev. 2011)

Rule 11.06: Verification Responsibilities of the Managed Care Entity

A managed care entity shall:

A. Obtain primary verification of at least the following information about the applicant:

1. Current license or certification to practice in this and all other states andhistory of licensure or certification;

2. Status of primary admitting hospital privileges, if applicable;

3. Specialty board certification status, or, if not board certified, the highest level of education obtained;

4. Malpractice history within the last five (5) years.

B. Obtain by either primary or secondary verification at the managed care entity's discretion:

1. Current level of professional liability coverage;

2. Practice history for at least five (5) years;

3. Status of hospital privileges other than the primary admitting hospital, if applicable;

4. Completion of medical, health care professional and/or post graduatetraining, other than the highest level of education obtained;

5. Current Drug Enforcement Agency (DEA) registration certificate, ifapplicable.

C. Every three (3) years obtain primary verification of a participating health careprofessional’s:

1. Current license or certification to practice in this and all other states;

2. Status of primary admitting hospital privileges, if applicable;

3. Specialty board certification status, if applicable;

4. An update regarding the health care professional’s malpractice history.

D. Every three (3) years obtain, by either primary or secondary verification, at themanaged care entity’s discretion:

1. Status of the health care professional’s hospital privileges other than theprimary admitting hospital, if applicable;

2. Current level of professional liability coverage;

3. Current DEA registration certificate, if applicable;

E. Require all participating providers to notify the managed care entity of changes in the status of any of the items listed in this Section at any time and identify for participating providers the individual to whom they should report changes in the status of an item listed in this Section.

Source: *Miss Code Ann* §§83-5-1; 83-41-413 (Rev. 2011)

Rule 11.07: Uniform Application for Physician Credentialing and Recredentialing

A. In order to simplify the application process for physicians who are applying to multiple managed care entities, the Commissioner hereby adopts a basic uniform credentialing application which shall be used by all managed care entities performing physician credentialing and recredentialing activities in Mississippi. The uniform application is attached hereto as Exhibit “A” and hereby made a part of this Regulation.

B. The uniform application may be augmented by an individual managed care entity for the purpose of obtaining additional necessary and material information which is not requested in the uniform application, and further, for the purpose of providing more detailed instructions regarding the completion and submission of the application. The additional information/instructions may only be requested/provided on supplemental sheets which are attached to the uniform application. Any proposed supplemental sheets must be submitted by the managed care entity to the Commissioner for prior approval.

C. The form prescribed by this Section shall apply only to the credentialing and recredentialing of physicians.

Source: *Miss Code Ann* §§83-5-1; 83-41-413 (Rev. 2011)

Rule 11.08: Health Care Professional's Right to Review Credentialing Verification Information

Subject to the provisions of Subsections A., B., C., and D. of this Section, a managed care entity shall provide a health care professional with the sources from which credentialing information is received, notification of any information that varies substantially from the information the health care professional provided, and the opportunity to correct information received from a third party that is incorrect or misleading.

A. Each health care professional who is subject to the credentialing verification process shall have the right to request information regarding the sources utilized by the managed care entity to verify credentialing information, including asummary of information obtained by the managed care entity to satisfy therequirements of this Regulation.

B. A managed care entity shall notify a health care professional of any information obtained during the managed care entity's credentialing verification process that does not meet the managed care entity's credentialing verification standards or that varies substantially from the information provided to the managed care entity by the health care professional, except, that the managed care entity shall not be required to allow the health care professional to (1) review the contents of a verification, (2) identify the source of information, or (3) provide a summary of differing information, if the information is not obtained to meet the requirements of this Regulation or if disclosure is prohibited by law. Responses provided by personal or professional references shall not be available to the health care professional.

C. A health care professional shall have the right to correct any erroneous information submitted by a third party when the health care professional feels that the managed care entity's credentialing verification committee has received information that is incorrect or misleading. The managed care entity shall have a formal process by which the health care professional may submit supplemental or corrected information to the managed care entity's credentialing verification committee. Supplemental information shall be subject to confirmation by the managed care entity.

D. Nothing in this Section 8 shall prohibit a managed care entity from denying an application or reapplication or terminating privileges, employment or a provider participation agreement where a health care professional intentionally withholds material information, intentionally omits material information, or intentionally submits material false or misleading information in a credentialing or re-credentialing application which is submitted to a managed care entity.

Source: *Miss Code Ann* §§83-5-1; 83-41-413 (Rev. 2011)

Rule 11.09: Contracting

Whenever a managed care entity delegates the credentialing functions required by this Regulation to another entity, the commissioner shall hold the managed care entity responsible for monitoring the activities of the delegatee entity in order to ensure that the requirements of this Regulation are met.

Source: *Miss Code Ann* §§83-5-1; 83-41-413 (Rev. 2011)

Rule 11.10: Separability

If any provision of the Regulation, or the application of the provision to any person or circumstance, shall be held invalid, the remainder of the Regulation, and the applicationof the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Source: *Miss Code Ann* §§83-5-1; 83-41-413 (Rev. 2011)

Rule 11.11: Effective Date

This Regulation shall become effective thirty (30) days after filing with the Office of the Secretary of State of the State of Mississippi.

Source: *Miss Code Ann* §25-43-3.113(Rev. 2010)

Rule 11.12: Instructions for Completing the Mississippi Participating Physician Application

To effectively use the Application, the following is suggested:

Type or legibly complete the Application in **black ink.**

A. Complete all of the Application **except for line 1, "This application is submitted to,___". Do not sign and date the original.** Keep the completed original on file and keep a blank original for future up-dates. Sign and date as directed below.

B. When submitting the Mississippi Participating Physician Application to a credentialing entity:

1. copy the original Application and any addenda the credentialing entity has requested;
2. fill in the name of the IPA, medical group, health plan, hospital, etc., to which the Application is being submitted on the top of page 1;
3. sign and date the copy in the spaces provided;
4. mail the signed and dated copy to the requesting organization.

C. By doing the above, your signature will be an original and the date will be current. Remember that the information on the Application must be complete and accurate. An incomplete Application may delay processing.

D. Submit completed Applications and do not rely on attached information unless requested.

E. If an item in the Application does not apply to you, write N/A in the box provided.

F. Attach copies of the documents requested on page 1 of the Application **each time** the Application is submitted.

G. For your convenience and to ensure information accuracy, keep Application current at all times.

If you have any questions, please call the Managed Care Entity to which you are submitting this Application.

Source: *Miss Code Ann* §§83-5-1; 83-41-413 (Rev. 2011)

Rule 11.13: Mississippi Participating Physician Application

(See below.)

Source: *Miss Code Ann* §§83-5-1; 83-41-413 (Rev. 2011)

CONFIDENTIAL/PROPRIETARY

Mississippi Participating Physician Application

lease check one:

] Original Application

] Reapplication

his application is submitted to: ______________________________, herein, this Managed Care Entity[1].

Section A.

Practice, Educational, Licensure and Work History Information

I. INSTRUCTIONS

This form should be typed or legibly printed in black ink. If more space is needed than provided on original, attach additional sheets and reference the questions being answered. Please do not use abbreviations when completing the application. If an item in the application does not apply to you, write N/A in the box provided. **Current copies of the following documents must be submitted with this application:**

- State Medical License(s)
- DEA Certificate
- Board Certification (if applicable)
- Face Sheet of Professional Liability Policy or Certification
- Curriculum Vitae
- ECFMG (if applicable)

II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Is there any other name under which you have been known (AKA/Maiden Name)? Name(s):		
Home Mailing Address:	City:	
	State:	ZIP:
Home Telephone Number: ( )	E-Mail Address:	
Home Fax Number: ( )	Pager Number: ( )	
Birthday Date: Birth Place (City/State/Country):	Citizenship (If not a United States citizen, please include copy of Alien Registration Card).	
Social Security # :	Gender[2]: ☐ Male ☐ Female	
Specialty:	Race/Ethnicity[2] (voluntary):	
Subspecialties:		

III. PRACTICE INFORMATION

Practice Name (if applicable):	Department Name (if Hospital based):
Primary Office Street Address:	Primary Office Mailing Address if different from Street Address:
City: State: County: Zip:	City: State: County: Zip:
Telephone Number: ( )	Fax Number: ( )
Office Manager/Administrator:	Telephone Number: ( )
	Fax Number: ( )
Name Affiliated with Tax ID Number:	Federal Tax ID Number:

[1] As used in the Information Release/Acknowledgements Section of this application, the term "this Managed Care Entity" shall refer to the entity to which the application is submitted as identified above.

[2] This information will be used for consumer information purposes only.

Secondary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number: ( )	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Teritary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number: ( )	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Handicap Access: ☐ Yes ☐ No	24-Hour Coverage: ☐ Yes ☐ No	
Will you accept new patients? ☐ Yes ☐ No	Back Office Telephone Number: ( )	

Please identify other networks in which you participate:

Please identify other networks from which you have been denied admission or de-selected:

Name of Network	Address	Reason for Denial or Deselection

Do you have ownership in any health or medical related organization, e.g., laboratory, home health care agency, radiology facility, lithotrips, mobile testing, MRI, etc.? ☐ Yes ☐ No

If yes, please list:

Medical Group(s) / IPA(s) Affiliation:

Do you intend to serve as a primary care provider? ☐ Yes ☐ No	Please check all that apply:
Do you intend to serve as a specialist? ☐ Yes ☐ No	☐ Solo Practice ☐ Single Specialty
If yes, please list specialty(s):	☐ Group Practice ☐ Multi Specialty

Do you employ any allied health professionals (e.g., nurse practitioners, physician assistants, psychologists, etc.)? ☐ Yes ☐ No

If so, please list:

Name:	Type of Provider:	License Number:

Do you personally employ any physicians? (Do not include physicians that are employed by the medical group) ☐ Yes ☐ No

Name:	Mississippi Medical License Number:

Please list any clinical services you perform that are not typically associated with your specialty:

Please list any clinical services you do not perform that are typically associated with your specialty:

Is your practice limited to certain ages? ☐ Yes ☐ No If yes, specify limitations:

Do you participate in EDI (electronic data interchange)? ☐ Yes ☐ No
If so, which Network?

Do you use a practice management system/software: ☐ Yes ☐ No
If so, which one?

What type of anesthesia do you provide in your group/office?
☐ Local ☐ Regional ☐ Conscious Sedation ☐ General ☐ None ☐ Other (please specify)________

Has your office received any of the following accreditations, certifications or licensures?
☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) ☐ Medicare Certification
☐ Mississippi Department of Health Licensure ☐ Other________

IV. BILLING INFORMATION

Billing Company:

Street Address:	City:	
	State:	ZIP:
Contact:	Telephone Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	

V. OFFICE HOURS - Please indicate the hours your office is open:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Holidays

VI. COVERAGE OF PRACTICE

(List your answering service and covering physicians by name. Attach additional sheets if necessary. Reference this section number and title.)

Answering Service Company:	Telephone Number: ( )	Fax Number: ( )
Mailing Address:	City:	
	State:	ZIP:
Covering Physician's Name:	Telephone Number: ( )	
Covering Physician's Name:	Telephone Number: ( )	
Covering Physician's Name:	Telephone Number: ( )	
Covering Physician's Name:	Telephone Number: ( )	

If you do not have hospital privileges, please provide written plan for continuity of care:

VII. FOREIGN LANGUAGES SPOKEN

Fluently by Physician:	Fluently by Staff:

VIII. LABORATORY SERVICES

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one.

Tax ID#	Billing Name:	Type of Service Provided:

Do you have a CLIA Certificate? ☐ Yes ☐ No

Do you have a CLIA waiver? ☐ Yes ☐ No

Certificate Number:

Certificate Expiration Date:

IX. MEDICAL/PROFESSIONAL EDUCATION (Attach additional sheets if necessary. Reference this section number and title.)

Medical School:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State & Country:	ZIP:
Medical/Professional School:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State & Country:	ZIP:

X. INTERNSHIP/PGYI (Attach additional sheets if necessary. Reference this section number and title.)

Institution:	Program Director:	
Mailing Address:	City:	
	State & Country:	ZIP:

Type of Internship:

Specialty:	From: (mm/yy)	To: (mm/yy)

XI. RESIDENCES/FELLOWSHIPS (Attach additional sheets if necessary. Reference this section number and title.)

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic), and postgraduate education in chronological order, giving name, address, city, state, country, zip code and dates. Include all programs you attended, whether or not completed.

Institution:	Program Director:	
Mailing Address:	City:	
	State & Country:	ZIP:

Type of Training (eg. residency, etc.):	Specialty:	From: (mm/yy)	To: (mm/yy)

Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)

Institution:			Program Director:		
Mailing Address:			City:		
			State & Country:		ZIP:
Type of Training:	Specialty:		From: (mm/yy)		To: (mm/yy)

Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)

Institution:			Program Director:		
Mailing Address:			City:		
			State & Country:		ZIP:
Type of Training (eg. residency, etc.):	Specialty:		From: (mm/yy)		To: (mm/yy)

Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)

XII. BOARD CERTIFICATION (Attach copies of documents.)

Include certifications by board(s) which are duly organized and recognized by:

- a member board of the American Board of Medical Specialties
- a member board of the American Osteopathic Association
- a board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty.

Name of Issuing Board:	Specialty:	Certification Number:	Date Certified/Recertified:	Expiration Date (if any):

Have you applied for board certification other than those indicated above? ☐ Yes ☐ No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of admissibility for certification on separate sheet.

Have you taken or failed a board exam? ☐ Yes ☐ No If yes, provide details.

XIII. OTHER CERTIFICATIONS (e.g., Fluoroscopy, Radiography, etc.) (Attach additional sheets if necessary. Reference this section number and title.)

Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

XIV. MEDICAL LICENSURE/REGISTRATIONS (Attach copies of documents.)

Mississippi State Medical License Number:	Issue Date:	Expiration Date:	Active: ☐ Yes ☐ No
Drug Enforcement Administration (DEA) Registration Number: Unlimited? ☐ Yes ☐ No If no, please explain on separate sheet		Expiration Date:	
Controlled Dangerous Substances Certificate (CDS) (if applicable):		Expiration Date:	

ECFMG Number (applicable to foreign medical graduates):		Date Issued:	Valid Through:
Visa Number:		Date Issued:	Valid Through:
Medicare UPIN/National Physician Identifier (NPI):	Mississippi Medicare Number:	Mississippi Medicaid Number:	

XV. ALL OTHER STATE MEDICAL LICENSES – List all Medical Licenses Now or Previously Held.

(Attach additional sheets if necessary. Reference this section number and title.)

State:	License Number:	Expiration Date:	Active: ☐ Yes ☐ No
State:	License Number:	Expiration Date:	Active: ☐ Yes ☐ No
State:	License Number:	Expiration Date:	Active: ☐ Yes ☐ No

XVI. PROFESSIONAL ORGANIZATIONS

Please list county, state or national medical societies, or other professional organizations or societies of which you are a member or applicant.

ORGANIZATION NAME	Applicant	Member
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Are you an Officer or Director of any of the professional organizations listed above? ☐ Yes ☐ No

If yes, please list:

XVII. PROFESSIONAL LIABILITY (Attach copy of professional liability policy or certification face sheet.)

Current Insurance Carrier:	Policy Number:	Original effective date:	
Mailing Address:		City:	
		State & Country:	ZIP:
Telephone Number: ( )	Fax Number: ( )		
Per Claim Amount: $	Aggregate Amount: $	Expiration Date:	

Please explain any surcharges to your professional liability coverage on a separate sheet. Reference this section number and title.

If you have had professional liability carriers in the last five years other than the one listed above, please list them below.

Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State and Country:	Zip:
Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State and Country:	Zip:

Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State and Country:	Zip:
Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State and Country:	Zip:

XVIII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in (A) in reverse chronological order, with the most current affiliation(s) first, all institutions with which you are currently affiliated. List previous affiliations during the past ten years in (B). Include hospitals, surgery centers, institutions, corporations, military assignments, or government agencies.

A. CURRENT AFFILIATIONS (Attach additional sheets if necessary. Reference this section number and title.)

Name and Mailing Address of Primary Admitting Hospital:	City:	
	State:	Zip:
Department/Status (Active, provisional, courtesy, etc.):	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	Zip:
Department/Status	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	Zip:
Department/Status	Appointment Date:	

If you do not have hospital privileges, please explain.

B. PREVIOUS AFFILIATIONS (Limit to last ten years. Attach additional sheets if necessary. Reference this section number and title.)

Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	Zip:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	
Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	Zip:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	
Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	Zip:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	

Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	Zip:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	

XIX. PEER REFERENCES

List three professional references, preferably from your specialty area. Do not list relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges. Do not include program directors previously listed under post graduate training and education in Section X.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through a close working relationship.

Name of Reference:	Specialty:	Telephone Number: ( )	
Mailing Address:		City:	
		State:	Zip:
Name of Reference:	Specialty:	Telephone Number: ( )	
Mailing Address:		City:	
		State:	Zip:
Name of Reference:	Specialty:	Telephone Number: ( )	
Mailing Address:		City:	
		State:	Zip:

XX. WORK HISTORY (Attach additional sheets if necessary. Reference this section number and title.)

Chronologically list all work history for at least the past five years (use extra sheets if necessary). This information must be complete. A curriculum vitae is sufficient provided it is current and contains all information requested below. Please explain any gaps in professional work history on a separate page.

Current Practice:	Contact Name:	Telephone Number: ( )	
		Fax Number: ( )	
Mailing Address:		City:	
		State:	Zip:
From: (mm/yy)	To: (mm/yy)		
Name of Practice/Employer:	Contact Name:	Telephone Number: ( )	
		Fax Number: ( )	
Mailing Address:		City:	
		State:	Zip:
From: (mm/yy)	To: (mm/yy)		

Name of Practice/Employer:	Contact Name:	Telephone Number: ( )
		Fax Number: ( )
Mailing Address:		City:
		State: Zip:
From: (mm/yy)	To: (mm/yy)	

Section B.
Professional Liability Action Explanation

Please complete this Section for each pending, settled, or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past five (5) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Section B prior to completing, and complete a separate form for each lawsuit.

I. CASE INFORMATION

City, County and State where lawsuit filed:	Court case number, if known:		
Date of alleged incident serving as basis for the lawsuit/arbitration:	Date Suit Filed:	Sex of patient:	Age of patient:

Location of Incident: ☐ Hospital ☐ My office ☐ Other doctor's office ☐ Surgery Center

☐ Other, (please specify) ____________________

Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consultant, etc.):

Allegation:

Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ☐ Yes ☐ No

If yes, please provide company name, contact person, phone number, location and claim identification number of insurance company or other liability protection company or organization.

____

____

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney to serve as your authorization:

Name____________________ Phone Number (______)____________

Name____________________ Phone Number (______)____________

II. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (Circle One)

☐ Lawsuit/arbitration still ongoing, unresolved.

☐ Judgment rendered and payment was made on my behalf. Amount paid on my behalf: ____________

☐ Judgment rendered and I was found not liable.

☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: ____________

☐ Lawsuit/arbitration settled, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheet(s). Include: (1) condition and diagnosis at time of incident, (2) dates and description of treatment rendered, and (3) condition of patient subsequent to treatment. Please print.

SUMMARY

Section C.
Certification

I certify that the information in Sections A and B of this application and any attached documents (including my curriculum – vitae, if attached) is true, current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges, employment or physician participation agreement. I agree that the Managed Care Entity to which this application is submitted, its representatives, and any individuals or entities providing information to this Managed Care Entity in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this Mississippi Participating Physician Application. In order for participating Managed Care Entities or healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Managed Care Entity information about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorneys listed in Section B, Page 9, to discuss any information regarding the subject case with this Managed Care Entity.

Print Name Here ____________________

Physician Signature ____________________ Date ____________
(Stamped Signature Is Not Acceptable)

Section D.
Attestation Questions

Please answer the following questions "yes" or "no". If your answer to any question is "yes," please provide full details on separate sheet.

1. Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?
Yes ☐ No ☐

2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?
Yes ☐ No ☐

3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?
Yes ☐ No ☐

4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?
Yes ☐ No ☐

5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?
Yes ☐ No ☐

6. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?
Yes ☐ No ☐

7. Have you been denied certification/recertification by a specialty board, or has your admissibility, certification or recertification status changed (other than changing from admissible to certified)?
Yes ☐ No ☐

8. Have you ever been convicted of any crime (other than a minor traffic violation)?
Yes ☐ No ☐

9. Are you currently engaged in the illegal use of drugs? ("Illegal use of drugs" means the use of controlled substances, obtained illegally, as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. "Currently" does not mean on the day of or even the weeks preceeding the completion of this application, rather, it means recently enough so that the illegal use may have an impact on one's ability to practice.)
Yes ☐ No ☐

10. Have any judgments or claims been entered against you, or settlements been agreed to by you within the last five (5) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending?
Yes ☐ No ☐

11. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank?
Yes ☐ No ☐

12. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g., reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?
Yes ☐ No ☐

13. Are you capable of performing all the services required by your agreement with, or the professional staff by laws of, the Managed Care Entity to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients, yourself or others?
Yes ☐ No ☐

14. Have you ever been reprimanded, censured, excluded, suspended, or disqualified by CLIA, or any other health plan for which you provided services?
Yes ☐ No ☐

I hereby affirm that the information submitted in this Section D Attestation Questions, and any addenda thereto is true, current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges, employment or physician participation agreement.

Print Name Here ____________________

Physician Signature ____________________ Date ____________

(Stamped Signature Is Not Acceptable)

Section E.

Information Release/Acknowledgements

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between "this Managed Care Entity" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and businesses and individuals acting as their agents (collectively, "Healthcare Organizations"), for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state[3] laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Managed Care Entity engaged in quality assessment, peer review and credentialing on behalf of this Managed Care Entity and all persons and entities providing credentialing information to such representatives of this Managed Care Entity from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Managed Care Entity to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Managed Care Entity as may be required by state and federal law and regulation.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Managed Care Entity or Healthcare Organization. I agree to notify this Managed Care Entity immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Managed Care Entity in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the Mississippi Board of Medical Licensure taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Managed Care Entity or Healthcare Organization which has resulted in the filing of a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Managed Care Entity or Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations), or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I understand and acknowledge that the National Practitioner Data Bank may be queried on my behalf to secure information about my history. A photocopy or facsimile of this document shall be as effective as the original, however, original signatures and current dates are required on pages 10, 11 and 12 of this application.

Print Name Here ______________________________

Physician Signature ______________________________ Date ______________

(Stamped Signature Is Not Acceptable)

Individual Managed Care Entities may request additional information or attach supplements to this form. Such additions or supplements are not part of the Mississippi Participating Physician Application and have not been endorsed by the organizations below. Questions about supplements should be addressed to the Managed Care Entity requesting them.

This Application is endorsed by:

- **Mississippi Association of Health Plans**
- **Mississippi State Medical Association**
- **Mississippi Hospital Association**

[3] The intent of this release is to apply, at a minimum, protections comparable to those available in Mississippi to any action, regardless of where such action is brought.

Chapter 12: (2000-2) Newborns' and Mothers' Health Protection**.**

Rule 12.01: Authority

This Regulation is promulgated pursuant to the authority vested in the Commissioner of Insurance under Miss. Code Ann. §§ 83-1-43 and 83-5-1 (Rev. 1999), and is promulgated in accordance with Mississippi Insurance Department Regulation No. 88-101, said Regulation being the Rules of Practice and Procedure Before the Mississippi Insurance Department.

Source: *Miss. Code Ann.* §83-1-43 **(**Rev. 2011)_

Rule 12.02: Purpose and Intent

In order to fully comply with the Health Insurance Portability and Accountability Act of 1996, as Amended, including information issued by the Health Care Financing Administration to the Mississippi Department of Insurance regarding the enforcementthereof, this Regulation is promulgated to prevent health insurance issuers in the groupor individual market that cover hospitalization in connection with childbirth for mothersand/or their newborns from restricting coverage to less than forty-eight (48) hours following a vaginal delivery and ninety-six (96) hours following a Cesarean section.

Source**:** *Miss. Code Ann.* §83-1-43_**(**Rev. 2011)_

Rule 12.03: Definition of Health Insurance Issuer

As used in this Regulation, the term "health insurance issuer" shall mean any insurance company, hospital or medical service plan or any entity defined in Miss. Code Ann. § 83-41-303(n) (Rev. 1999), which offers group or individual insurance coverage in the State of Mississippi.

Source**:** *Miss. Code Ann.* §83-5-1; 83-1-43_(Rev. 2011**)**_

Rule 12.04: Benefit Requirements for Minimum Hospital Stay

A. A health insurance issuer shall not, except as provided in subsection B. of thisSection:

1. Restrict benefits for any hospital length of stay in connection with child-birth for the mother or newborn child following a normal vaginaldelivery to less than forty-eight (48) hours; or

2. Restrict benefits for any hospital length of stay in connection withchildbirth for the mother or newborn child following a Caesarean section to less than ninety-six (96) hours; or

3. Require that a provider obtain authorization from the health insurance issuer for prescribing any length of stay required in this Section 4.

B. The provisions of the Section 4. shall not apply in connection with any healthissuer in any case in which the decision to discharge the mother or her newborn child before the expiration of the minimum length stay otherwise required undersubsections (1) and (2) of Section 4. is made by an attending provider in consultation with the mother.

Source**:** *Miss. Code Ann.* §83-1-43 (Rev. 2011)

Rule 12.05: Prohibited Practices

A health insurance issuer offering a group or individual health insurance coverage shall not:

A. Deny to the mother or her newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the policy solely for the purpose of avoiding the requirements of this Regulation;

B. Provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available under this Regulation;

C. Penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an insured or enrollee in accordance with this Regulation;

D. Provide incentives, monetary or otherwise, to an attending provider to induce such provider to provide care to an insured or enrollee in a manner inconsistent with this Regulation; or

E. Subject to subsection C. of Section 6. of this Regulation, restrict benefits for any portion of a period within a hospital length of stay required under subsections (1) and (2) of Section 4. of this Regulation in a manner which is less favorable than the benefits provided for any preceding portion of such stay.

Source:*Miss. Code Ann.* §83-1-43_(Rev. 2011)_

Rule 12.06: Exceptions

A. Nothing in this Regulation shall be construed to require a mother who is an insured or enrollee:

    1. To give birth in a hospital; or
    2. To stay in the hospital for a fixed period of time following the birth ofher child.

B. This Regulation shall not apply with respect to any group or individual health insurance coverage offered by a health insurance issuer which does not provide benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child.

C. Nothing in this Regulation shall be construed as preventing a health insurance issuer form imposing deductibles, coinsurance or other cost-sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or newborn child under group or individual health insurance coverage, except that such coinsurance or other cost-sharing for any portion of a period within a hospital length of stay required under subsections (1) and (2) of Section 4. of this Regulation may not be greater than such coinsurance or cost-sharing for any preceding portion of such stay.

D. Nothing in this Regulation shall be construed to prevent a health insurance issuer
E. offering group or individual health insurance coverage from negotiating the
F. level and type of reimbursement with a provider for care provided in accordance
G. with this Regulation.

Source:*Miss. Code Ann.* §83-1-43_(Rev. 2011)

Rule 12.07: Notice

A health insurance issuer providing group or individual health insurance coverage shall provide notice to the named insured in the case of an individual policy, and to each certificate holder in the case of a group policy, regarding the coverage required by this Regulation. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the health insurance issuer and shall be transmitted to the named insured or certificate holder not later than October 1, 2000. The notice prescribed by this Section 7. shall be filed with and approved by the Commissioner of Insurance before distribution by the health insurance issuer.

Source**:** *Miss. Code Ann.* §83-1-43_(Rev. 2011)

Rule 12.08: Effective Date

The effective date of this Regulation shall be thirty (30) days from and after its adoption and filing with the Secretary of State of the State of Mississippi.

Source**:** *Miss. Code Ann.* §25-43-3.113_(Rev. 2010)

Chapter 13: (2000-3) Women's Health and Cancer Rights**.**

Rule 13.01: Authority

This Regulation is promulgated pursuant to the authority vested in the Commissioner of Insurance under Miss. Code Ann. §§ 83-1-43 and 83-5-1 (Rev. 1999).and is promulgated in accordance with Mississippi Insurance Department Regulation No. 88-101, said Regulation being the Rules of Practice and Procedure Before the Mississippi Insurance Department.

Source**:** *Miss. Code Ann.* §83-1-43_(Rev. 2011)_

Rule 13.02: Purpose and Intent

In order to fully comply with the Health Insurance Portability and Accountability Act of 1996, as Amended, including instructions issued by the Health Care Financing Administration regarding the enforcement thereof, this Regulation is promulgated to require health insurance issuers in the group and individual markets that cover medical and surgical benefits with respect to a mastectomy to cover, for patients who so elect:

A. Reconstruction of the breast on which the mastectomy has been preformed;

B. Surgery and reconstruction of the other breast to produce a symmetrical appearance;

C. Prosthesis, and physical complications of mastectomy, including lymphedema.

Source**:** *Miss. Code Ann.* §83-1-43_(Rev. 2011)_

Rule 13.03: Definition of Health Insurance Issuer

As used in this Regulation, the term "health insurance issuer" shall mean any insurance company, hospital or medical service plan or any entity defined in Miss. Code Ann. §83-41-303(n) (Rev. 1999), which offers group or individual health insurance coveragein the State of Mississippi.

Source**:** *Miss. Code Ann.* §83-1-43_(Rev. 2011)_

Rule 13.04: Benefit Requirements

A health insurance issuer providing group or individual health insurance coverage that provides medical and surgical benefits with respect to a mastectomy shall provide aninsured or enrollee who is receiving benefits in connection with a mastectomy and whoelects breast reconstruction in connection with such mastectomy, coverage for all stagesof reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications of mastectomy, including lymphedema in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemedappropriate and as are consistent with those established for other benefits under the coverage. Written notice of the availability of such coverage shall be delivered to the insured in the case of an individual policy, and to the certificate holder in the case of a group policy, upon enrollment and annually thereafter.

Source**:** *Miss. Code Ann.* §83-1-43_(Rev. 2011)_

Rule 13.05: Prohibited Practices

A. A health insurance issuer offering group or individual health insurance coveragemay not:

1. Deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the policy solely for the purpose of avoiding the requirements of this Regulation; or

2. Penalize or otherwise reduce or limit the reimbursement of an attending provider or provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an insured or enrollee in a manner inconsistent with this Regulation.

B. Nothing in this Regulation shall be construed to prevent a health insurance issuer offering group or individual health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this Regulation.

Source**:** *Miss. Code Ann.* §83-1-43_(Rev. 2011)_

Rule 13.06: Notice

A health insurance issuer providing group or individual health insurance coverage shall provide notice to the named insured in the case of an individual policy, and to each certificate holder in the case of a group policy, regarding the coverage required by this Regulation. Such notice shall be in writing and prominently positioned in any literature or correspondence made available or distributed by the health insurance issuer and shall be transmitted to the named insured or certificate holder not later than October 1, 2000. The notice prescribed by the Section 6. shall be filed with and approved by the Commissioner of Insurance before distribution by the health insurance issuer.

Source: *Miss. Code Ann.* §83-1-43_(Rev. 2011)_

Rule 13.07: Exceptions

This Regulation does not apply to any group health insurance coverage in relation to its provision of excepted benefits described in 42 U.S.C. § 300gg-21(c) and (d), and does not apply to any individual health insurance coverage in relation to its provision of expected benefits described in 42 U.S.G. § 300gg-63.

Source: *Miss. Code Ann.* §83-1-43_(Rev. 2011)_

Rule 13.08: Effective Date

The effective date of this Regulation shall be thirty (30) days from and after its adoption and filing with the Secretary of State of the State of Mississippi.

Source**:** *Miss. Code Ann.* §25-43-3.113_(Rev. 2010)