

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, both companies and agents are hereby advised that effective November 15, 1957, ALL CHECKS SHALL BE MADE PAYABLE EITHER TO THE COMPANY OR TO AN AUTHORIZED STATE AGENCY, rather than to the individual agent making the sale.

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 30th Day 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 to adopt the interpretation of the National Association of Insurance Commissioners 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, for at 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 used only 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 no right 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 premium rates 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 and advertising 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: Accident and Health Insurance Policies, Rates and Other Endorsement Filings (As Amended).

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.

Pursuant to such authority, every insurance company, either foreign or domestic, authorized to transact 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 filing 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, 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.

No benefit changes shall be implemented by any insurance company applicable to any accident and sickness policy until written notice is provided to the policyholder at least seventy-five (75) days prior to the effective date of the benefit change. For the purposes of this Regulation, the term “benefit change” shall mean any change to the choice of benefits, benefit limits or benefit duration limits that are not requested by a policyholder. Notice of the benefit changes may be sent by U.S. Mail or electronically where the policyholder conducts transactions with the insurance company electronically, subject to the provisions of the Mississippi Uniform Electronic Transactions Act.

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 seventy- five (75) 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.

The provisions of this Regulation shall not apply to long-term care insurance or any accident and health group plan that is preempted by the provisions of The Employee Retirement Income Security Act of 1974.

The amendments to this Regulation shall become effective on and after January 1, 2021.

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 control over 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 descriptive literature 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 which reduces 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 which restricts 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 an advertisement which is neither an invitation to inquire nor an institutional advertisement.

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

Rule 5.04: Method Of Disclosure 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 And Content 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 help fill some of the gaps that Medicare and your present insurance leave out”; “this policy 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 beyond the 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 is a benefit, such as, describing a waiting period as a “benefit builder”, or stating “even pre-existing conditions are covered after two years”. Words and phrases used in an advertisement to describe such policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of such limitations, 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 similar words or phrases because such words and phrases have the capacity, tendency or 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 automobile accidents, 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 shall not imply that because "no insurance agent will call and no commissions will be paid to agents" that it is "a low cost plan", or use other similar words or phrases 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 any exceptions and reductions, such as: "This policy is subject to the following minimum 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 if the 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’s physical 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 “no medical 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 the first ____year(s) after the issue date for a disease or physical condition which 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 any loss incurred during the first ____year(s) after the issue date on account of disease 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 For Disclosing 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 manner which 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 accurately reproduce. 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 relationship between an organization and the insurer is disclosed. If the entity making the endorsement 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 be disclosed in the advertisement.
- D. When a testimonial refers to benefits received under a policy, the specific claim date, including claim number, date of loss, and other pertinent information shall be retained by the insurer for inspection for a period of four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

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 provided depends 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 various benefits 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 incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other 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 limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.
- 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 in an 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 and 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 prospective insureds 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 not available at a later date, or that the offer is available only to a specified group of individuals, 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 unless there 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 franchise insurance. 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 that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages 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 different benefits 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 in connection with advertisements of accident or accident and sickness insurance.

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

Rule 5.16: Statements about an Insurer

An advertisement shall not contain statements which are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement shall not contain a

recommendation by any commercial rating system unless it clearly indicates the purpose of the recommendation and the limitations of the scope and extent of 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 individual policies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state whether or not licensed in such other state, with a notation attached to each such advertisement which shall indicate the manner and extent of distribution and the form number of any policy 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 Department with 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, information and belief the advertisements which were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of these rules and the Insurance Laws of this State as implemented and interpreted 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 and regulations 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 of accident and sickness insurance, Draft 4, dated April 16, 1974, of National Association of Insurance 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 of Mississippi to implement Sections 83-5-1, 83-17-129, 83-17-229, and 83-17-231 of the Mississippi Code of 1972, Annotated and Amended and Senate Bill 2482 as adopted by the 1986 Session of the Mississippi Legislature, and in accordance with Section 25-43-1 through 25-43-19, Mississippi Code of 1972, known as the Mississippi Administrative Procedures Law, do hereby promulgate the following Regulation with an effective date of thirty (30) days after promulgation and filing with the Office of the Secretary of State upon 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 to a 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 the insurance 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 the supervising general agent; whether the agent is incorporated or unincorporated.
- 2. Specific functions, authority and responsibilities granted by the insurance 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 to determine 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 supervising general 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 and filing 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 coronary care 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 coverage’s, 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. Code Ann. 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 than obtaining 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 obtaining insurance, 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 not 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 insured individual or certificate holder; 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 lower levels 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 or certificate thereunder issued to a group as defined in Section 4E(1) may exclude 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 hospitalization requirement;
 - 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 recuperative benefits 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 limitations contained 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 any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described.
 - d. A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contain 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 by the acceleration of the death benefit, is in benefit payment status, a monthly report 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 cash values, 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 explanatory language in accordance with the disclosure requirements of Section 8 of this Regulation.
1. No such policy issued to an individual shall contain renewal provisions less favorable 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 the premium and investment income associated with the policies; and
 - ii. The policies will continue to experience substantial and unexpected losses over their lifetime; and
 - iii. The projected loss experience of the policies cannot be significantly improved or mitigated through reasonable rate adjustments or other reasonable methods; and
 - iv. The insurer has made repeated and good faith attempts to stabilize loss experience 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 in this state as long-term care insurance if such policy limits or excludes coverage by type 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 intentionally self-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 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 continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and 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 existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies which restrict provision of benefits and services to, or contain 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, provider system 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 insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy he or 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’s failure 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 which the policy is issued and for which it

may be renewed. This provision shall not apply to policies which do not contain a renewability provision, and under which the 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 any limitations with respect to preexisting conditions, such limitations shall appear as a 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

**are
address).**

3. Prior to issuance of a long-term care policy or certificate to applicant age eighty (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 is applicable) shall be delivered to the insured no later than at the time of delivery 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 insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated and shall annually furnish this

information to the Insurance Commissioner 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 of Insurance 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 coverage is 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. **BENEFITS 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 Association plan 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: Regulation to Implement The Medicare Supplement Insurance Minimum Standards Model Act.

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; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

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.

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 Rules 10.07, 10.13, 10.14, 10.17 and 10.22, 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 Employees Health 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 Rule 10.14, 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 Rules 10.07A(1), 10.08A(1), and 10.08.1A(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 Rules 10.07A(4), (5) and (7), and 10.08A(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 for Pre-Standardized Medicare Supplement Benefit 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 Rule 10.08.1B 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 [\$185];
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 Rule 10.08A(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 Rule 10.08A(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 Rule 10.09 of this regulation) to a 2010 Standardized plan (as described in Rule 10.09.1 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 Rule 10.09 of this regulation.

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

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

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

4. Eighty Percent (80%) of the Medicare Part B Excess Charges: Coverage for eighty percent (80%) of the difference between the actual Medicare Part B 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:

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

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

(III) \$1,600 per calendar year;

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

(V) Care furnished on a visiting basis in the insured's home; (VI) Services provided by a care provider as defined in this section;

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

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

c. Coverage is excluded for:

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

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

D. Standards for Plans K and L.

1. Standardized Medicare supplement benefit plan "K" shall consist of the following:

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

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

c. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate

Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

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

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

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

Rule 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 this regulation.

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

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.
2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, 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 Rule 10.08.1A(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 Rule 10.08.1A(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. 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; 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.
6. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

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 Rule 10.08B 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 Rule 10.09G and in Rule 10.10 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 Rule 10.04 of this regulation. Each benefit shall be structured in accordance

with the format provided in Rules 10.08B and 10.08C, or 10.08D and list the benefits in the order shown in this subsection. For purposes of this section, “structure, language, and format” means style, arrangement and overall content of a benefit.

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

E. Make-up of benefit plans:

1. Standardized Medicare supplement benefit plan “A” shall be limited to the basic (core) benefits common to all benefit plans, as defined in Rule 10.08B of this regulation.

2. Standardized Medicare supplement benefit plan “B” shall include only the following: The core benefit as defined in Rule 10.08B of this regulation, plus the Medicare Part A deductible as defined in Rule 10.08C(1).

3. Standardized Medicare supplement benefit plan “C” shall include only the following: The core benefit as defined in Rule 10.08B 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 Rules 10.08C(1), (2), (3) and (8) respectively.

4. Standardized Medicare supplement benefit plan “D” shall include only the following: The core benefit (as defined in Rule 10.08B of this regulation), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in Rules 10.08C(1), (2), (8) and (10) respectively.

5. Standardized Medicare supplement benefit plan “E” shall include only the following: The core benefit as defined in Rule 10.08B 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 Rule 10.08C(1), (2), (8) and (9) respectively.

6. Standardized Medicare supplement benefit plan “F” shall include only the following: The core benefit as defined in Rule 10.08B 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 Rule 10.08C(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 Rule 10.08B 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 Rule 10.08C(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 Rule 10.08B 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 Rules 10.08C(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 Rule 10.08B 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 Rules 10.08C(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 Rule 10.08B 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 Rules 10.08C(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 Rule 10.08B 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 Rules 10.08C(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 Rule 10.08B 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 Rules 10.08C(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The annual high deductible plan “J” deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan “J” policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be \$1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

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

1. Standardized Medicare supplement benefit plan “K” shall consist of only those benefits described in Rule 10.08 D(1).

2. Standardized Medicare supplement benefit plan “L” shall consist of only those benefits described in Rule 10.08 D(2).

G. 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.

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

Rule 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 10, 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 this regulation.

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 Rule 10.08.1B of this regulation.

2. If an issuer makes available any of the additional benefits described in Rule 10.08.1C, or offers standardized benefit Plans K or L (as described in Rules 10.09.1E(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 Rule 10.09.1E(3) of this regulation) or standardized benefit Plan F (as described in Rule 10.09.1E(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 Rule 10.09.1F and in Rule 10.0 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 Rule 10.04 of this regulation. Each benefit shall be structured in accordance with the format provided in Rules 10.08.1B and 10.08.1C of this regulation; or, in the case of plans K or L, in Rule 10.09.1E(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 Rule 10.08.1B of this regulation.
2. Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in Rule 10.08.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible as defined in Rule 10.08.1C(1) of this regulation.
3. Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in Rule 10.08.1B 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 Rules 10.08.1C(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 Rule 10.08.1B 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 Rule 10.08.1C(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 Rule 10.08.1B 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 Rule 10.08.1C(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 Rule 10.08.1B 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 Rule 10.08.1C(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 Rule 10.08.1B 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 Rule 10.08.1C(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 Rule 10.08.1B 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 Rules 10.08.1C(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 Rule 10.08.1B 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 Rules 10.08.1C(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.

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

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of Miss. Code Ann. § 83-9-101 to 115, and this regulation.

A. Benefit Requirements. The standards and requirements of Rule 10.09.1 shall apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:

1. Standardized Medicare supplement benefit Plan C is redesignated as Plan D and shall provide the benefits contained in Rule 10.09.1E(3) of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.
2. Standardized Medicare supplement benefit Plan F is redesignated as Plan G and shall provide the benefits contained in Rule 10.09.1E(5) of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.

3. Standardized Medicare supplement benefit plans C, F, and F with High Deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.
 4. Standardized Medicare supplement benefit Plan F With High Deductible is redesignated as Plan G With High Deductible and shall provide the benefits contained in Rule 10.09.1E(6) of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible; provided further that, the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible.
 5. The reference to Plans C or F contained in Rule 10.09.1A(2) is deemed a reference to Plans D or G for purposes of this section.
- B. Applicability to Certain Individuals. This Rule 10.09.2, applies to only individuals that are newly eligible for Medicare on or after January 1, 2020:
1. By reason of attaining age 65 on or after January 1, 2020; or
 2. By reason of entitlement to benefits under part A pursuant to Section 226(b) or 226A of the Social Security Act, or who is deemed to be eligible for benefits under Section 226(a) of the Social Security Act on or after January 1, 2020.
- C. Guaranteed Issue for Eligible Persons. For purposes of Rule 10.12E, in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F With High Deductible) shall be deemed to be a reference to Medicare supplement policy D or G (including G With High Deductible), respectively, that meet the requirements of this Rule 10.09.2A.
- D. Applicability to Waivered States. In the case of a State described in Section 1882(p)(6) of the Social Security Act (“waivered” alternative simplification states) MACRA prohibits the coverage of the Medicare Part B deductible for any Medicare supplement policy sold or issued to an individual that is newly eligible for Medicare on or after January 1, 2020.
- E. Offer of Redesignated Plans to Individuals Other Than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in Subparagraph A(4), above may be offered to any individual who was eligible for Medicare prior to January 1, 2020, in addition to the standardized plans described in Rule 10.09.1E of this regulation.

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

Rule 10.10: Medicare Select Policies and Certificates

- A. 1. This section shall apply to Medicare Select policies and certificates, as defined in this section.
2. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.
- B. For the purposes of this section:
1. “Complaint” means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.
2. “Grievance” means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.
3. “Medicare Select issuer” means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.
4. “Medicare Select policy” or “Medicare Select certificate” mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.
5. “Network provider” means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.
6. “Restricted network provision” means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.
7. “Service area” means the geographic area approved by the 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. 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:
1. Evidence that all covered services that are subject to restricted network

provisions are available and accessible through network providers, including a demonstration that:

- a. Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.
 - b. The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:
 - i. To deliver adequately all services that are subject to a restricted network provision; or
 - ii. To make appropriate referrals.
 - c. There are written agreements with network providers describing specific responsibilities.
 - d. Emergency care is available twenty-four (24) hours per day and seven (7) days per week.
 - e. In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.
- 2. A statement or map providing a clear description of the service area.
 - 3. A description of the grievance procedure to be utilized.
 - 4. A description of the quality assurance program, including:
 - a. The formal organizational structure;
 - b. The written criteria for selection, retention and removal of network providers; and
 - c. The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

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

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

7. Any other information requested by the 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 requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.

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

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

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

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

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

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: of the first month in which an individual is both sixty-five years of age or older and is enrolled for benefits under Medicare Part B Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

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

a preexisting condition.

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

C. Except as provided in Subsection B and Sections Rules 10.12 and 10.23, 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.

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

Rule 10.12: Guaranteed Issue for Eligible Persons

A. Guaranteed Issue.

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

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

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

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

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

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

- b. The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;
 - c. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area;
 - d. The individual demonstrates, in accordance with guidelines established by the Secretary, that:
 - i. The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or
 - ii. The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
 - e. The individual meets such other exceptional conditions as the Secretary may provide.
3. a. The individual is enrolled with:
- i. An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost);
 - ii. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;
 - iii. An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or iv. An organization under a Medicare Select policy; and
- b. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Rule 10.12B (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 Rule 10.12B(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 Rule 10.12B(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. Rule 10.12B(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), Rule 10.12B(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. Rule 10.12B(6) shall include any Medicare supplement policy offered by any issuer;

4. Rule 10.12B(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 Rule 10.12A. 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 for Claims Payment

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

1. Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;
2. Notifying the participating physician or supplier and the beneficiary of the payment determination;
3. Paying the participating physician or supplier directly;
4. Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;
5. Paying user fees for claim notices that are transmitted electronically or otherwise; and
6. Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

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

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

Rule 10.14: Loss Ratio Standards and Refund or Credit Of Premium

A. Loss Ratio Standards.

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

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

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

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

i. Home office and overhead costs;

- ii. Advertising costs;
- iii. Commissions and other acquisition costs;
- iv. Taxes;
- v. Capital costs;
- vi. Administrative costs;and
- vii. Claims processing costs.

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

3. For purposes of applying Subsection A(1) of this section and Subsection C(3) of Rule 10.15 only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

4. For policies issued prior to 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 this regulation, 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 this regulation, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the commissioner.

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

Rule 10.15: Filing and Approval of Policies and Certificates and Premium Rates

A. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the 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 Rule 10.14 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.

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	F	F*	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			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit \$[5560]; paid at 100%	Out-of-pocket limit \$[2780]; paid at 100%		

*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 [\$2300] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$2300] Out-of- pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible

PREMIUM INFORMATION [Boldface Type]

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

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 Rule 10.09.1D 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 \$[1364]	\$0	\$[1364](Part A deductible)
61st thru 90th day	All but \$[341] a day	\$[341] a day	\$0
91st day and after: —While using 60 lifetime reserve days	All but \$[682] a day	\$[682] a day	\$0
—Once lifetime reserve days are used:	\$0	100% of Medicare eligible expenses	\$0**
—Additional 365 days			
—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
21 st thru 100th day	All but \$[170.50] a day	\$0	Up to \$[170.50] a day
101 st day and after	\$0	\$0	All costs

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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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 \$[185] 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 \$[185] of Medicare Approved Amounts*	\$0	\$0	\$[185] (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 \$[185] of Medicare Approved Amounts*	\$0	\$0	\$[185] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
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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	\$0	\$0	\$[185] (Part B deductible)
First \$[185] of Medicare Approved Amounts*			
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 \$[1364]	\$[1364](Part A deductible)	\$0
61 st thru 90th day	All but \$[341] a day	\$[341] a day	\$0
91 st day and after:			\$0
—While using 60 lifetime reserve days	All but \$[682] a day	\$[682] a day	
—Once lifetime reserve days are used:			\$0**
—Additional 365 days	\$0	100% of Medicare eligible expenses	
—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
21 st thru 100 th day	All but \$[170.50] a day	\$0	Up to \$[170.50] 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 B

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

* Once you have been billed \$[185] 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 \$[185] of Medicare Approved Amounts*	\$0	\$0	\$[185] (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 \$[185] of Medicare Approved Amounts*	\$0	\$0	\$[185] (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 \$[185] of Medicare Approved Amounts*	\$0	\$0	\$[185] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	0%

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1364]	\$[1364](Part A deductible)	\$0
61 st thru 90th day	All but \$[341] a day	\$[341] a day	\$0
91 st day and after: —While using 60 lifetime reserve days	All but \$[682] a day	\$[682] a day	\$0
—Once lifetime reserve days are used:	\$0	100% of Medicare eligible expenses	\$0**
Additional 365 days —Beyond the additional 365 days	\$0	\$0	All costs

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

101st day and after

All but \$[170.50] a day

Up to \$[170.50] a day

\$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	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 \$[185] 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 \$[185] of Medicare Approved Amounts*	\$0	\$[185] (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 \$[185] of Medicare Approved Amounts*	\$0	\$[185] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN C
PARTS A & B

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	\$0	\$[185](Part B deductible)	\$0
First \$[185] of Medicare Approved Amounts*			
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 \$[1364]	\$[1364] (Part A deductible)	\$0
61st thru 90th day	All but \$[341] a day	\$[341] a day	\$0
91st day and after: —While using 60 lifetime reserve days	All but \$[682] a day	\$[682] a day \$0	\$0
—Once lifetime reserve days are used:	\$0	100% of Medicare eligible expenses	\$0**
Additional 365 days —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
21 st thru 100th day	All but \$[170.50] a day	Up to \$[170.50] a day	\$0
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 D

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

* Once you have been billed \$[185] 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 \$[185] of Medicare Approved Amounts*	\$0	\$0	\$[185] (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 \$[185] of Medicare Approved Amounts*	\$0	\$0	\$[185] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN D
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment	\$0	\$0	\$[185] (Part B deductible)
First \$[185] of Medicare Approved Amounts*			
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN D
OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

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

[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2300] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$2300]. 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 \$[2300] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2300] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[1364]	\$[1364] (Part A deductible)	\$0
61st thru 90 th day	All but \$[341] a day	\$[341] a day	\$0
91st day and after: —While using 60 Lifetime reserve days	All but \$[682] a day	\$[682] 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

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD (cont.)

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2300] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2300] 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 \$[170.50] a day	Up to \$[170.50] a day	\$0
101 st 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/co- insurance	\$0

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

PLAN F or HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed \$[185] 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 [\$2300] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [\$2300]. 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 \$[2300] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[2300] 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 \$[185] of Medicare Approved amounts*	\$0	\$[185] (Part B deductible)	\$0
Remainder of Medicare Approved amounts	Generally 80%	Generally 20%	\$0

PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[185] of Medicare Approved amounts*	\$0	\$[185] (Part B deductible)	\$0
Remainder of Medicare Approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES— TESTS FOR	100%	\$0	\$0

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2300] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[2300] DEDUCTIBLE,**
HOME HEALTH CARE Medicare Approved Services - Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[185] of Medicare Approved Amounts*	\$0	\$[185] (Part B deductible)	\$0
Remainder of Medicare — Approved Amounts	80%	20%	\$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[2300] DEDUCTIBLE,* * PLAN PAYS	IN ADDITION TO \$[2300] DEDUCTIBLE, ** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary Emergency care services Beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN G or HIGH DEDUCTIBLE PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[1364]	\$[1364] (Part A deductible)	\$0
61st thru 90th day	All but \$[341] a day	\$[341] a day	\$0
91st day and after: —While using 60 lifetime reserve days	All but \$[682] a day	\$[682] a day	\$0
—Once lifetime reserve days are used:	\$0	100% of Medicare eligible expenses	\$0**
—Additional 365 days	\$0	\$0	All costs
—Beyond the additional 365 days			
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
21 st thru 100th day	All but \$[170.50] a day	Up to \$[170.50] 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 or HIGH DEDUCTIBLE PLAN G

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

* Once you have been billed \$[185] 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 \$[185] of Medicare Approved Amounts*	\$0	\$0	\$185 (Unless_Part B deductible has been met)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[185] of Medicare Approved Amounts*	\$0	\$0	\$185(Unless_Part B Deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN G or HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$2,300 DEDUCTIBLE] PLAN PAYS	[IN ADDITION TO \$2,300 DEDUCTIBLE] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[185] of Medicare Approved Amounts*	\$0	\$0	\$185 (Unless Part B Deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[5560] 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 \$[1364]	\$[682](50% of Part A deductible)	\$[682](50% of Part A deductible)♦
61 st thru 90th day	All but \$[341] a day	\$[341] a day	\$0
91st day and after: —While using 60 lifetime reserve days	All but \$[682] a day	\$[682] 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

PLAN K
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD
(cont.)

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 21 st thru 100th day 101st day and after	 All approved amounts. All but \$[170.50] a day \$0	 \$0 Up to \$[85.25] a day (50% of Part A Coinsurance) \$0	 \$0 Up to \$[85.25] a day (50% of Part A Coinsurance)♦ All costs
BLOOD First 3 pints Additional amounts	 \$0 100%	 50% \$0	 50% ♦ \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	50% of co-payment/ coinsurance	50% of Medicare co-payment/coinsurance ♦

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

PLAN K

**** Once you have been billed \$[185] 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 \$[185] of Medicare Approved Amounts****	\$0	\$0	\$[185] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75-80% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out- of-pocket limit of [\$5560])*

BLOOD			
First 3 pints	\$0	50%	50% ♦
Next \$[185] of Medicare Approved Amounts****	\$0	\$0	\$[185] (Part B deductible)**** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	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 \$[5560] 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 \$[185] of Medicare Approved Amounts*****	\$0	\$0	\$[185] (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 \$[2780] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year.

However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION ** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[1364]	\$[1023] (75% of Part A deductible)	\$[1023] (75% of Part A deductible) ♦
61 st day thru 90 th day	All but \$[341] a day	\$[341] a day	\$0
61 st day and after:			
- While using 60 lifetime reserve days	All but \$[682] a day	\$[682] a day	\$0
- Once lifetime reserve days are used			
- Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
- Beyond 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
21 st thru 100 th day	All but \$[170.50] a day	Up to \$[127.88] a day (75% of Part A Coinsurance)	Up to \$[127.88] a day (75% of Part A Coinsurance) ♦
101 st day and after	\$0	\$0	All costs
BLOOD First 3 pints	\$0	75%	25% ♦
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	75% of co-payment/coinsurance	25% of co-payment/coinsurance ♦

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

PLAN L

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

**** Once you have been billed \$[185] 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 \$[185] of Medicare Approved Amounts****	\$0	\$0	\$[185] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 80% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$2780])*

BLOOD			
First 3 pints	\$0	75%	25% ♦
Next \$[185] of Medicare Approved Amounts****	\$0	\$0	\$[185] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[2780] 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 \$[185] of Medicare Approved Amounts*****	\$0	\$0	\$[185] (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 \$[1364]	\$[682](50% of Part A deductible)	\$[682](50% of Part A deductible)
61 st thru 90th day	All but \$[341] a day	\$[341] a day	\$0
91 st day and after: —While using 60 lifetime reserve days	All but \$[682] a day	\$[682] 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 \$[170.50] a day	Up to \$[170.50] a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0

HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0
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**** 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 \$[185] 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 \$[185] of Medicare Approved Amounts*	\$0	\$0	\$[185] (Part B deductible) \$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[185] of Medicare Approved Amounts*	\$0	\$0	\$[185] (Part B deductible) \$0
Remainder of Medicare Approved Amounts	80%	20%	
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN M
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[185] of Medicare Approved Amounts*	\$0	\$0	\$[185](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 \$[1364]	\$[1364](Part A deductible)	\$0
61 st thru 90th day	All but \$[341] a day	\$[341] a day	\$0
91 st day and after: —While using 60 lifetime reserve days	All but \$[682] a day	\$[682] 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
21 st thru 100th day	All but \$[170.50] a day	Up to \$[170.50] 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 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 \$[1364]	\$[1364] (Part A deductible)	\$0
61 st thru 90 th day	All but \$[341] a day	\$[341] a day	\$0
91 st day and after			\$0
-While using 60 lifetime reserve days	All but \$[682] a day	\$[682] a day	
-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 21 st thru 100 th day 101 st day and after	 All approved amounts All but \$[170.50] a day \$0	 \$0 Up to \$[170.50] a day \$0	 \$0 \$0 All costs
BLOOD First 3 pints Additional Amounts	 \$0 100%	 Three 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 outpatient drugs and inpatient respite care	Medicare co-payment/coninsurance	\$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 the billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B) – MEDICAL SERVICES – PER 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 \$[185] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Balances, 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.	 \$[185] (Part B deductible) 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 \$[185] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$[185] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN N
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment	\$0	\$0	\$[185] (Part B deductible)
First \$[185] of Medicare Approved Amounts*			
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN N
OTHER BENEFITS—NOT COVERED BY MEDICARE

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

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

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 Rule 10.03B 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 REPLACEMENT OF MEDICARE
SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE**

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

_____ Additional benefits.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums.

_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

_____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. [optional only for Direct Mailers.]

_____ Other. (please specify) _____

1. **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing 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 For Advertising

An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the 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 for Marketing

A. An issuer, directly or through its producers, shall:

1. Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.
2. Establish marketing procedures to assure excessive insurance is not sold or issued.
3. Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

“Notice to buyer: This policy may not cover all of your medical expenses.”

4. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

5. Establish auditable procedures for verifying compliance with this Subsection A.

B. In addition to the practices prohibited in 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 of Recommended Purchase and Excessive Insurance

A. In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. Any sale of a Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

C. An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage

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 against Preexisting Conditions, Waiting Periods, Elimination Periods And Probationary Periods in Replacement Policies or Certificates

A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate 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 or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

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

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

D. Subsection C shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with Subsection A.

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

F. Notwithstanding Subsection C, an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

1. The request is made pursuant to research that complies with Part 46 of Title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.
 2. The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that
 - a. Compliance with the request is voluntary; and
 - b. Non-compliance will have no effect on enrollment status or premium or contribution amounts.
 3. No genetic information collected or acquired under this Subsection shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.
 4. The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this Subsection, including a description of the activities conducted.
 5. The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this Subsection.
- G. An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.
- H. An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.
- I. If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of Subsection H if such request, requirement, or purchase is not in violation of Subsection G.
- J. For the purposes of this Section only:
1. "Issuer of a Medicare supplement policy or certificate" includes third-party administrator, or other person acting for or on behalf of such issuer.

2. “Family member” means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.
3. “Genetic information” means, with respect to any individual, information about such individual’s genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term “genetic information” does not include information about the sex or age of any individual.
4. “Genetic services” means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.
5. “Genetic test” means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term “genetic test” does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.
6. “Underwriting purposes” means,
- a. Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;
 - b. The computation of premium or contribution amounts under the policy;
 - c. The application of any 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 and its amendments shall be effective on ~~June 30, 2009~~ and after January 1, 2020.

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 I _____ SMSBP2 _____

For the State of _____ Company **Name** _____ NAIC
Group Code _____ NAIC Company Code _____ AddressPerson Completing Exhibit _____
Title _____ Telephone **Number** _____

Line		(a) Earned Premiums	(b) Incurred Claims ⁴
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues		
	c. Net (for reporting purposes= 1a-1b)		
2.	Past Years' Experience (all policy years)		
3.	Total Experience (Net Current Year+ Past Year)		
4.	Refunds Last Year (Excluding Interest)		
5.	Previous Since Inception (Excluding Interest)		
6.	Refunds Since Inception (Excluding Interest)		
7.	Benchmark Ratio Since Inception (<i>see worksheet for Ratio 1</i>)		
8.	Experienced Ratio Since Inception (<i>Ratio 2</i>) Total Actual Incurred Claims <u>line 3, col. b2</u> 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 _____

TYPE¹ _____ SMSBP² _____
 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 _____

TYPE¹ _____ SMSBP² _____ 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)	(d)	(g)	(h)	(i)	(j)	(o)s
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: $(1 + n)/(k + m)$: _____

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans

3 Year 1 is the current calendar year-1. Year 2 is the current calendar year-2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

⁴ For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

⁵ These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

⁶ To include the earned premium for all years prior to as well as the 15th year prior to the current year.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR _____

TYPE¹ _____ SMSBP² _____
 For the State of _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing Exhibit _____
 Title _____ Telephone Number _____

(a) ³ Year	(b) ⁴ Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)	(k) ⁵ 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: $(1 + n)/(k + m)$: _____

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) Health 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, utilization review 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 science of medicine and who has received the degree of doctor of medicine or osteopathy from an accredited and recognized school or college of medicine or osteopathic medicine.

I. “Primary verification” means verification by the managed care entity of a healthcare professional’s credentials based upon evidence obtained from the issuing source 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 means other 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 And Scope

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 contracts and 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 professional credentialing verification;
 3. Establish a credentialing verification committee consisting of licensed physicians and other health care professionals to review credentialing verification information and supporting documents and make decisions regarding 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 credentialing verification process, 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 and history 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 graduate training, other than the highest level of education obtained;
 5. Current Drug Enforcement Agency (DEA) registration certificate, if applicable.
- C. Every three (3) years obtain primary verification of a participating health care professional'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 the managed care entity's discretion:
1. Status of the health care professional's hospital privileges other than the primary 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 a summary of information obtained by the managed care entity to satisfy the requirements 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 application of 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)

Mississippi Participating Physician Application

Please check one:

☐ Original Application☐ Reapplicationhis application is submitted to: _____, herein, this Managed Care Entity¹.

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 : <input type="checkbox"/> Male <input type="checkbox"/> 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:	
Tertiary 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: <input type="checkbox"/> Yes <input type="checkbox"/> No		24-Hour Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will you accept new patients? <input type="checkbox"/> Yes <input type="checkbox"/> 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.? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please list:			
Medical Group(s) / IPA(s) Affiliation:			
Do you intend to serve as a primary care provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		Please check all that apply:	
Do you intend to serve as a specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Solo Practice <input type="checkbox"/> Single Specialty	
If yes, please list specialty(s):		<input type="checkbox"/> Group Practice <input type="checkbox"/> Multi Specialty	
Do you employ any allied health professionals (e.g., nurse practitioners, physician assistants, psychologists, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> 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/ELLOWSHIPS (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: <input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:	
Unlimited? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain on separate sheet			
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: <input type="checkbox"/> Yes <input type="checkbox"/> No
State:	License Number:	Expiration Date:	Active: <input type="checkbox"/> Yes <input type="checkbox"/> No
State:	License Number:	Expiration Date:	Active: <input type="checkbox"/> Yes <input type="checkbox"/> 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
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

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 _____

(Stamped Signature Is Not Acceptable)

Date _____

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 preceding 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 _____

(Stamped Signature Is Not Acceptable)

Date _____

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 state³ 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 enforcement thereof, this Regulation is promulgated to prevent health insurance issuers in the group or individual market that cover hospitalization in connection with childbirth for mothers and/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 this Section:

1. Restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child following a normal vaginal delivery to less than forty-eight (48) hours; or
2. Restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child following a Cesarean 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 health issuer 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 under subsections (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 of her 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 from 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 coverage in 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 an insured or enrollee who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for all stages of 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 deemed appropriate 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 coverage may 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 excepted 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)

Chapter 14: Managed Care Plan Network Adequacy

Rule 14.01. Title

This Regulation shall be known and may be cited as the Managed Care Plan Network Adequacy Regulation and is promulgated by the Commissioner of Insurance pursuant to the authority granted to him by Title 83, the Mississippi Insurance Code; the requirements of *Miss. Code Ann.* §§ 25-43-1.101, et seq., the Mississippi Administrative Procedures Law; and the requirements of *Miss. Code Ann.* §§ 83-41-401, et seq., the Mississippi Patient Protection Act of 1995.

Source: *Miss. Code Ann.* §§ 25-43-1.101, et seq.; § 83-5-1; §§ 83-41-401, et seq. (Rev. 2022)

Rule 14.02. Purpose

The purpose of this Regulation is to establish standards for the creation and maintenance of networks by health carriers and to ensure adequate access to covered persons in a managed care plan. This Regulation enhances the adequacy, accessibility, and quality of health care services offered under a managed care plan. This Regulation also establishes requirements for written agreements between health carriers offering managed care plans and participating providers regarding the standards, terms, and provisions under which the participating provider will provide services to covered persons.

Source: *Miss. Code Ann.* § 83-41-405; § 83-41-413 (Rev. 2022)

Rule 14.03. Definitions

For purposes of this Regulation:

- A. “Commissioner” means the Commissioner of Insurance.
- B. “Covered benefits” or “benefits” means those health care services to which a covered person is entitled under the terms of a health benefit plan.
- C. “Covered person” means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.
- D. “Emergency medical condition” means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy.
- E. “Emergency services” means health care items and services furnished or required to evaluate and treat an emergency medical condition.

F. “Facility” means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

G. “Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

H. “Health care professional” means a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with state law.

I. “Health care provider” or “provider” means a health care professional or a facility.

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

K. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a third party administrator, a health maintenance organization, a nonprofit hospital, health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

L. “Intermediary” means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network.

M. “Managed care plan” means a plan as defined by *Miss. Code Ann.* § 83-41-403(b).

N. “Network” means the group of participating providers providing services to a managed care plan and who have entered into a contract of reimbursement for benefits with a health carrier.

O. “Participating provider” means a provider as defined by *Miss. Code Ann.* § 83-41-403(e).

P. “Person” means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

Q. “Primary care professional” means a participating health care professional

designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

Source: *Miss. Code Ann.* § 83-41-403; § 83-41-405; § 83-41-413 (Rev. 2022)

Rule 14.04. Applicability and Scope

This Regulation shall apply to all health carriers that offer managed care plans; provided, however, the Regulation shall not apply to the Mississippi State Employee Health Plan or to any managed care plan regulated by the Mississippi Division of Medicaid, or to any self-insured health plan.

Source: *Miss. Code Ann.* § 83-41-405; § 83-41-413 (Rev. 2022)

Rule 14.05. Network Adequacy

A. A health carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of participating providers to ensure that all covered services to covered persons will be accessible without unreasonable delay. In the case of emergency facility services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week.

B. The sufficiency of health carriers' networks shall be measured by the network adequacy standards outlined in 45 C.F.R. § 156.230((a)(2)(i) and associated guidance published by the Centers for Medicare and Medicaid Services.

C. In any case where the health carrier has an insufficient number or type of participating providers/facilities to provide a covered benefit to a covered person consistent with the geographic access standards set forth in Rule 14.05(B), the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers/facilities, and additionally, if the covered persons must travel more than one hundred (100) miles one way or more than the distance standard prescribed by this regulation, whichever is greater, to obtain the aforementioned covered benefit, the health carrier shall provide such persons reasonable round trip reimbursement for their food, lodging and travel. Reimbursement for food and lodging shall be at the prevailing federal per diem rates, then in effect, as set by the U.S. General Services Administration. Reimbursement for travel by vehicle shall be reimbursed at the current Internal Revenue Service mileage standard for miles driven for transportation or travel expenses. The health carrier's regulatory obligation in this Subsection C to provide such reimbursement shall not exceed \$10,000.00 per covered person in any applicable policy year.

D. The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers/facilities to the locations of covered persons. A health carrier may be deemed to be out of compliance with the geographic access standards in Rule 14.05(B) in the event that the health carrier is not able to meet the applicable time or distance minimum with respect to covered persons' locations. In determining whether a health carrier has complied with the geographic access standards in Rule 14.05(B), the Commissioner shall give due consideration to the relative availability of health care providers in the geographic area under consideration. The fact that no provider specialist, adult or pediatric, provides a covered service within the minimum geographic access standards shall be taken into consideration when determining whether a health carrier has complied with the geographic access standards in Rule 14.05(B), and the Commissioner may accept the attestation of a health carrier as sufficient even if the health carrier does not comply with Rule 14.05(B) and Rule 14.05(D) if the Commissioner determines the health carrier has made reasonable efforts to secure health care providers in the geographic area at issue, but such providers were not available. The Commissioner's assessment of the health carrier's efforts will be performed consistent with the Managed Care Plan Certification Regulation, Title 19, Part 3, Chapter 18.

1. A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, financial capability, and legal authority of its providers to furnish all contracted benefits to covered persons.
2. If a health carrier does not meet network adequacy standards in a particular geographic area, the Commissioner shall have authority to request and obtain from the health carrier data or information pertaining to the health carrier's efforts to comply with this section and to obtain contracts with providers/facilities and use this information in his determination under this provision. This authority shall extend to contracts offered to but declined by providers/facilities, and to provider applications that were denied by the health carrier. A health carrier shall maintain records as to all providers/facilities who apply to be a participating provider but were denied such status, along with an explanation of why such status was denied by the health carrier.

E. Beginning June 1, 2025, a health carrier shall file with the Commissioner, in addition to the information required to be submitted in this Regulation and the Managed Care Plan Certification Regulation, an access plan meeting the requirements of Rule 14.05 for each of the managed care plans that the carrier offers in this state. The health carrier shall make the access plans, absent proprietary or confidential commercial or financial information, available on its business premises and shall provide them to any interested party upon request. The health carrier shall prepare an access plan before offering a new managed care plan and shall update an existing access plan whenever it makes any material change to an existing managed care plan. The access plan shall describe or contain at least the following:

1. The health carrier's network;
2. The health carrier's procedures for making referrals within and outside its network;
3. The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in managed care plans;
4. The health carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;
5. The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;
6. The health carrier's method of informing covered persons of the plan's services and features, including, but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;
7. The health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;
8. The health carrier's process for enabling covered persons to change primary care professionals;
9. The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transferred to other providers in a timely manner; and
10. Any other information required by the Commissioner to determine compliance with the provisions of this Regulation.

Source: *Miss. Code Ann.* § 83-41-405; § 83-41-413 (Rev. 2022)

Rule 14.06. Requirements for Health Carriers and Participating Providers

A health carrier offering a managed care plan shall meet the following requirements contained in this section, in addition to any other requirements required under Mississippi law.

- A. A health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered or non-covered health services for which the provider will be responsible, including any limitations or conditions on services.
- B. Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for covered persons. This requirement shall be met by including a provision substantially similar to the following:

“Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier’s covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy.”

- C. Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, covered services to covered persons will continue through the period for which a premium has been paid to the health carrier on behalf of the covered person or until the covered person’s discharge from an inpatient facility, whichever time is greater. Covered benefits to covered persons confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary.
- D. The contract provisions that satisfy the requirements of Subsections B and C shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and shall supersede any oral or written contrary agreement between a participating provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered services

provisions required by Subsections B and C of this section.

- E. In no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the health carrier.
- F. 1. Health carrier selection standards for participating providers shall be developed for primary care professionals and each health care professional specialty. The standards shall be used in determining the selection of health care professionals by the health carrier, its intermediaries and any provider networks with which it contracts. As to physicians, the standards shall meet the requirements of 19 Miss. Admin. Code, Part 3, Rule 11, "Health Care Professional Credentialing Verification." Selection criteria shall not be established in a manner:
 - a. That would allow a health carrier to avoid high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher-than-average claims, losses or health services utilization; or
 - b. That would exclude providers because they treat or specialize in treating populations presenting a risk of higher-than-average claims, losses, or health services utilization.
- 2. Paragraphs (1)(a) and (1)(b) shall not be construed to prohibit a health carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the health carrier developed in compliance with this Regulation.
- 3. The provisions of this Regulation do not require a health carrier, its intermediaries or the provider networks with which they contract, to employ specific providers or types of providers that may meet their selection criteria, or to contract with or retain more providers or types of providers than are necessary to maintain an adequate network.
- G. A health carrier shall make its selection standards for participating providers available for review by the Commissioner.
- H. A health carrier shall notify participating providers of the providers' responsibilities with respect to the health carrier's applicable administrative policies and programs, including, but not limited to, terms of payment, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state programs.
- I. A health carrier shall not offer an inducement under the managed care plan to a provider to provide less than medically necessary services to a covered person.

- J. A health carrier shall not prohibit a participating provider from discussing treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance processes established by the health carrier or a person contracting with the health carrier.
- K. A health carrier shall require a participating provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.
- L. A health carrier and participating provider shall provide at least sixty (60) days written notice to each other before terminating the contract without cause. The health carrier shall make a good-faith effort to provide written notice of a termination within thirty (30) days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. Where a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. Within five (5) working days of the date that the provider either gives or receives notice of termination, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.
- M. The rights and responsibilities under a contract between a health carrier and a participating provider shall not be assigned or delegated by the participating provider without the prior written consent of the health carrier.
- N. A health carrier is responsible for ensuring that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the participating provider should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions.
- O. A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments, or deductibles from covered persons pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.
- P. A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.
- Q. A health carrier shall establish mechanism(s) by which the participating providers

may determine in a timely manner whether or not a person is covered by the health carrier, whether a particular service is covered, and whether a particular service requires pre-certification.

- R. A health carrier shall establish procedures for the resolution of administrative, payment or other disputes between providers and the health carrier.
- S. A contract between a health carrier and a participating provider shall include payment and reimbursement methodologies that are clearly described.
- T. A contract between a health carrier and a participating provider shall not contain definitions or other provisions that conflict with the definitions or provisions contained in the managed care plan or this Regulation.

Source: *Miss. Code Ann.* § 83-41-405; §83-41-411; and § 83-41-413 (Rev. 2022)

Rule 14.07. Intermediaries

A contract between a health carrier and an intermediary shall satisfy all the requirements contained in this section.

- A. Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of Rule 14.06.
- B. A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.
- C. A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.
- D. A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state or ensure that it has access to all intermediary subcontracts. A health carrier shall make copies of intermediary contracts available to the Commissioner upon demand.
- E. If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons.
- F. If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to covered persons at its principal place of business in the state and preserve them in a manner that facilitates regulatory review by the Commissioner.

G. An intermediary shall allow the Commissioner access to the intermediary's books, records, financial information, and any documentation of services provided to covered persons, as necessary to determine compliance with this Regulation.

H. A health carrier shall have the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services.

Source: *Miss. Code Ann.* § 83-41-405; § 83-41-413 (Rev. 2022)

Rule 14.08. Confidentiality

A health carrier may designate material submitted to the Commissioner pursuant to this regulation as confidential and exempt from disclosure to the public under the Mississippi Public Records Act if the health carrier deems the material to meet the criteria set forth in *Miss. Code Ann.* § 25-61-9(1).

Source: *Miss. Code Ann.* § 25-61-9; § 83-41-413 (Rev. 2022)

Rule 14.09. Contracting

A. The execution of a contract by a health carrier shall not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable regulations.

B. All contracts shall be in writing and subject to review.

C. All contracts shall comply with applicable requirements of the law and applicable regulations.

Source: *Miss. Code Ann.* § 83-41-405; § 83-41-413 (Rev. 2022)

Rule 14.10. Compliance and Penalties

The Commissioner may retain outside consultants to assist the Commissioner for determining compliance with this regulation, and the fees and costs of such consultants paid by the health carrier to the consultants pursuant to *Miss. Code Ann.* § 83-41-407. A violation of this Regulation shall be subject to the penalty provisions set forth in *Miss. Code Ann.* § 83-5-17, as well as other penalty provisions under applicable law.

Source: *Miss. Code Ann.* § 83-5-17; § 83-41-405; § 83-41-413 (Rev. 2022)

Rule 14.11. Severability

If any provision of this Regulation, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Regulation, and the application of 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. 2022)

Rule 14.12. Effective Date

This Regulation shall be effective thirty (30) days after final adoption with the Office of the Secretary of State. All provider and intermediary contracts in effect on the effective date of this Regulation, or which are issued or put in force on or after the effective date of this Regulation, shall comply with this Regulation no later than June 1, 2025. The Commissioner may extend this deadline for an additional period not to exceed six (6) months if the health carrier demonstrates good cause for an extension.

Source: *Miss. Code Ann.* § 25-43-3.112 (Rev. 2022)

Part 3, Chapter 15: Mississippi Health Carrier External Review Regulation

Rule 15.01. Purpose and Intent

The purpose of this Regulation is to provide uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination, as defined in this Regulation.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

Rule 15.02. Definitions

For purposes of this Regulation:

- A. “Adverse determination” means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated.
- B. “Ambulatory review” means utilization review of health care services performed or provided in an outpatient setting.

- C. “Authorized representative” means:
1. A person to whom a covered person has given express written consent to represent the covered person in an external review;
 2. A person authorized by law to provide substituted consent for a covered person; or
 3. A family member of the covered person or the covered person’s treating health care professional only when the covered person is unable to provide consent.
- D. “Best evidence” means evidence based on:
1. Randomized clinical trials;
 2. If randomized clinical trials are not available, cohort studies or case-control studies;
 3. If paragraphs (1) and (2) are not available, case-series; or
 4. If paragraphs (1), (2) and (3) are not available, expert opinion.
- E. “Case-control study” means a retrospective evaluation of two (2) groups of patients with different outcomes to determine which specific interventions the patients received.
- F. “Case management” means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.
- G. “Case-series” means an evaluation of a series of patients with a particular outcome, without the use of a control group.
- H. “Certification” means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier’s requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.
- I. “Clinical review criteria” means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health carrier to determine the necessity and appropriateness of health care services.
- J. “Cohort study” means a prospective evaluation of two (2) groups of patients with only one group of patients receiving a specific intervention(s).

- K. “Commissioner” means the Commissioner of Insurance.
- L. “Concurrent review” means utilization review conducted during a patient’s hospital stay or course of treatment.
- M. “Covered benefits” or “benefits” means those health care services to which a covered person is entitled under the terms of a health benefit plan.
- N. “Covered person” means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.
- O. “Discharge planning” means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.
- P. “Disclose” means to release, transfer or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.
- Q. “Emergency medical condition” means the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy.
- R. “Emergency services” means health care items and services furnished or required to evaluate and treat an emergency medical condition.
- S. “Evidence-based standard” means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.
- T. “Expert opinion” means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention or therapy.
- U. “Facility” means an institution providing health care services or a health care setting, including but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.
- V. “Final adverse determination” means an adverse determination involving a covered benefit that has been upheld by a health carrier, or its designee utilization

review organization, at the completion of the health carrier's internal grievance process procedures.

- W. "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.
- X. "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.
- Y. "Health care provider" or "provider" means a health care professional or a facility.
- Z. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.
- AA. "Health carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.
- BB. "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:
 - 1. The past, present or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;
 - 2. The provision of health care services to an individual; or
 - 3. Payment for the provision of health care services to an individual.
- CC. "Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations.
- DD. "Medical or scientific evidence" means evidence found in the following sources:
 - 1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

2. Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);
3. Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act;
4. The following standard reference compendia:
 - a. The American Hospital Formulary Service–Drug Information;
 - b. Drug Facts and Comparisons;
 - c. The American Dental Association Accepted Dental Therapeutics; and
 - d. The United States Pharmacopoeia–Drug Information;
5. Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:
 - a. The federal Agency for Healthcare Research and Quality;
 - b. The National Institutes of Health;
 - c. The National Cancer Institute;
 - d. The National Academy of Sciences;
 - e. The Centers for Medicare & Medicaid Services;
 - f. The federal Food and Drug Administration; and
 - g. Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or
6. Any other medical or scientific evidence that is comparable to the sources listed in paragraphs (1) through (5).

EE. “NAIC” means the National Association of Insurance Commissioners.

- FF. “Person” means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.
- GG. “Prospective review” means utilization review conducted prior to an admission or a course of treatment.
- HH. “Protected health information” means health information:
1. That identifies an individual who is the subject of the information; or
 2. With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.
- II. “Randomized clinical trial” means a controlled, prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time.
- JJ. “Retrospective review” means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.
- KK. “Second opinion” means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.
- LL. “Utilization review” means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.
- MM. “Utilization review organization” means an entity that conducts utilization review, other than a health carrier performing a review for its own health benefit plans.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

Rule 15.03. Applicability and Scope

- A. Except as provided in subsection B, this Regulation shall apply to all health carriers.
- B. The provisions of this Regulation shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by the Commissioner by regulation, vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the Commissioner by regulation, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

Rule 15.04. Notice of Right to External Review

- A.
 - 1. A health carrier shall notify the covered person in writing of the covered person's right to request an external review to be conducted pursuant to Rule 15.07, Rule 15.08 or Rule 15.09 of this Regulation and include the appropriate statements and information set forth in subsection B at the same time the health carrier sends written notice of:
 - a. An adverse determination upon completion of the health carrier's utilization review process; and
 - b. A final adverse determination.
 - 2. As part of the written notice required under paragraph (1), a health carrier shall include the following, or substantially equivalent, language: "We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested by submitting a request for external review to the Office of the Insurance Commissioner, Mississippi Insurance Department, Attn: Life and Health Actuarial Division, P.O. Box 79, Jackson, MS 39205, Phone: (601) 359-3569."

3. The Notice of Appeal Rights, attached hereto as Rule 15.20 - Appendix “A” meets all form and content requirements of this section.

B. 1. The health carrier shall include in the notice required under subsection A:

a. For a notice related to an adverse determination, a statement informing the covered person that:

i. If the covered person has a medical condition where the timeframe for completion of an expedited review of a grievance involving an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person’s ability to regain maximum function, the covered person or the covered person’s authorized representative may file a request for an expedited external review to be conducted pursuant to Rule 15.08 of this Regulation, or Rule 15.09 of this Regulation if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person’s treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated, at the same time the covered person or the covered person’s authorized representative files a request for an expedited review of a grievance involving on adverse determination, but that the independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited review of the grievance prior to conducting the expedited external review; and

ii. The covered person or the covered person’s authorized representative may file a grievance under the health carrier’s internal grievance process, but if the health carrier has not issued a written decision to the covered person or the covered person’s authorized representative within thirty (30) days following the date the covered person or the covered person’s authorized representative files the grievance with the health carrier and the covered person or the covered person’s authorized representative has not requested or agreed to a delay, the covered person or the covered person’s authorized representative may file a

request for external review pursuant to Rule 15.05 of this Regulation and shall be considered to have exhausted the health carrier's internal grievance process for purposes of Rule 15.06 of this Regulation; and

b. For a notice related to a final adverse determination, a statement informing the covered person that:

i. If the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to Rule 15.07 of this Regulation would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review pursuant to Rule 15.08 of this Regulation; or

ii. If the final adverse determination concerns:

I. An admission, availability of care, continued stay or health care service for which the covered person received emergency services, but has not been discharged from a facility, the covered person or the covered person's authorized representative may request an expedited external review pursuant to Rule 15.08 of this Regulation; or

II. A denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational, the covered person or the covered person's authorized representative may file a request for a standard external review to be conducted pursuant to Rule 15.07 of this Regulation or if the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated, the covered person or the covered person's authorized representative may request an expedited external review to be conducted under Rule 15.08 of this Regulation.

2. In addition to the information to be provided pursuant to paragraph (1), the health carrier shall include a copy of the description of both the standard

and expedited external review procedures the health carrier is required to provide pursuant to Rule 15.16 of this Regulation, highlighting the provisions in the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information and including any forms used to process an external review.

3. As part of any forms provided under paragraph (2), the health carrier shall include an authorization form, or other document approved by the Commissioner that complies with the requirements of 45 CFR Section 164.508, by which the covered person, for purposes of conducting an external review under this Regulation, authorizes the health carrier and the covered person's treating health care provider to disclose protected health information, including medical records, concerning the covered person that are pertinent to the external review.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

Rule 15.05. Request for External Review

- A.
 1. Except for a request for an expedited external review as set forth Rule 15.08 of this Regulation, all requests for external review shall be made in writing to the Commissioner.
 2. The External Review Request Form, attached hereto as Rule 15.21-Appendix "B", meets the form and requirements of this section and may be used to submit a request for External Review.
- B. A covered person or the covered person's authorized representative may make a request for an external review of an adverse determination or final adverse determination.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

Rule 15.06. Exhaustion of Internal Grievance Process

- A.
 1. Except as provided in subsection B, a request for an external review pursuant to Rule 15.07, Rule 15.08 or Rule 15.09 of this Regulation shall not be made until the covered person has exhausted the health carrier's internal grievance process.
 2. A covered person shall be considered to have exhausted the health carrier's internal grievance process for purposes of this section, if the covered person or the covered person's authorized representative:

- a. Has filed a grievance involving an adverse determination with the health carrier; and
 - b. Except to the extent the covered person or the covered person's authorized representative requested or agreed to a delay, has not received a written decision on the grievance from the health carrier within thirty (30) days following the date the covered person or the covered person's authorized representative filed the grievance with the health carrier.
 - 3. Notwithstanding paragraph (2), a covered person or the covered person's authorized representative may not make a request for an external review of an adverse determination involving a retrospective review determination until the covered person has exhausted the health carrier's internal grievance process.
- B.
 - 1.
 - a. At the same time a covered person or the covered person's authorized representative files a request for an expedited review of a grievance involving an adverse determination, covered person or the covered person's authorized representative may file a request for an expedited external review of the adverse determination:
 - i. Under Rule 15.08 of this Regulation if the covered person has a medical condition where the timeframe for completion of an expedited review of the grievance involving an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or
 - ii. Under Rule 15.09 of this Regulation if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment that is the subject of the adverse determination would be significantly less effective if not promptly initiated.

- b. Upon receipt of a request for an expedited external review under subparagraph (a) of this paragraph, the independent review organization conducting the external review in accordance with the provisions of Rule 15.08 or Rule 15.09 of this Regulation shall determine whether the covered person shall be required to complete the expedited review process before it conducts the expedited external review.
 - c. Upon a determination made pursuant to subparagraph (b) of this paragraph that the covered person must first complete the expedited grievance review process, the independent review organization immediately shall notify the covered person and, if applicable, the covered person's authorized representative of this determination and that it will not proceed with the expedited external review set forth in Rule 15.08 of this Regulation until completion of the expedited grievance review process and the covered person's grievance at the completion of the expedited grievance review process remains unresolved.
 - 2. A request for an external review of an adverse determination may be made before the covered person has exhausted the health carrier's internal grievance procedures whenever the health carrier agrees to waive the exhaustion requirement.
- C. If the requirement to exhaust the health carrier's internal grievance procedures is waived under subsection B(2), the covered person or the covered person's authorized representative may file a request in writing for a standard external review as set forth in Rule 15.07 or Rule 15.09 of this Regulation.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

Rule 15.07. Standard External Review

- A.
 - 1. Within four (4) months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Rule 15.04 of this Regulation, a covered person or the covered person's authorized representative may file a request for an external review with the Commissioner.
 - 2. Within one (1) business day after the date of receipt of a request for external review pursuant to paragraph (1), the Commissioner shall send a copy of the request to the health carrier.

- B. Within five (5) business days following the date of receipt of the copy of the external review request from the Commissioner under subsection A(2), the health carrier shall complete a preliminary review of the request to determine whether:
1. The individual is or was a covered person in the health benefit plan at the time the health care service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service was provided;
 2. The health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;
 3. The covered person has exhausted the health carrier's internal grievance process unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to Rule 15.06 of this Regulation; and
 4. The covered person has provided all the information and forms required to process an external review, including the release form provided under Rule 15.04(B) of this Regulation.
- C. 1. Within one (1) business day after completion of the preliminary review, the health carrier shall notify the Commissioner and covered person and, if applicable, the covered person's authorized representative in writing whether:
- a. The request is complete; and
 - b. The request is eligible for external review.
2. If the request:
- a. Is not complete, the health carrier shall inform the covered person and, if applicable, the covered person's authorized representative and the Commissioner in writing and include in the notice what information or materials are needed to make the request complete; or
 - b. Is not eligible for external review, the health carrier shall inform the covered person, if applicable, the covered person's authorized

representative and the Commissioner in writing and include in the notice the reasons for its ineligibility.

3.
 - a. The Commissioner may specify the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice.
 - b. The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the Commissioner.
 4.
 - a. The Commissioner may determine that a request is eligible for external review under Rule 15.07(B) of this Regulation notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.
 - b. In making a determination under subparagraph (a) of this paragraph, the Commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this Regulation.
 - D.
 1. Whenever the Commissioner receives a notice that a request is eligible for external review following the preliminary review conducted pursuant to subsection C, within one (1) business day after the date of receipt of the notice, the Commissioner shall:
 - a. Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the Commissioner pursuant to Rule 15.11 of this Regulation to conduct the external review and notify the health carrier of the name of the assigned independent review organization; and
 - b. Notify in writing the covered person and, if applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review.
 2. In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review process.

3. The Commissioner shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within five (5) business days following the date of receipt of the notice provided pursuant to paragraph (1) additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after five (5) business days.
- E.
1. Within five (5) business days after the date of receipt of the notice provided pursuant to subsection D(1), the health carrier or its designee utilization review organization shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination.
 2. Except as provided in paragraph (3), failure by the health carrier or its utilization review organization to provide the documents and information within the time specified in paragraph (1) shall not delay the conduct of the external review.
 3.
 - a. If the health carrier or its utilization review organization fails to provide the documents and information within the time specified in paragraph (1), the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.
 - b. Within one (1) business day after making the decision under subparagraph (a), the independent review organization shall notify the covered person, if applicable, the covered person's authorized representative, the health carrier, and the Commissioner.
- F.
1. The assigned independent review organization shall review all of the information and documents received pursuant to subsection E and any other information submitted in writing to the independent review organization by the covered person or the covered person's authorized representative pursuant to subsection D(3).
 2. Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to subsection D(3), the assigned independent review organization shall within one (1) business day forward the information to the health carrier.
- G.
1. Upon receipt of the information, if any, required to be forwarded pursuant to subsection F(2), the health carrier may reconsider its adverse

determination or final adverse determination that is the subject of the external review.

2. Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to paragraph (1) shall not delay or terminate the external review.
 3. The external review may only be terminated if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care service that is the subject of the adverse determination or final adverse determination.
 4.
 - a. Within one (1) business day after making the decision to reverse its adverse determination or final adverse determination, as provided in paragraph (3), the health carrier shall notify the covered person, if applicable, the covered person's authorized representative, the assigned independent review organization, and the Commissioner in writing of its decision.
 - b. The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subparagraph (a) of this paragraph.
- H. In addition to the documents and information provided pursuant to subsection E, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:
1. The covered person's medical records;
 2. The attending health care professional's recommendation;
 3. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative, or the covered person's treating provider;
 4. The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;
 5. The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines

developed by the federal government, national or professional medical societies, boards and associations;

6. Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization; and
 7. The opinion of the independent review organization's clinical reviewer or reviewers after considering paragraphs (1) through (6) to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- I.
1. Within forty-five (45) days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to:
 - a. The covered person;
 - b. If applicable, the covered person's authorized representative;
 - c. The health carrier; and
 - d. The Commissioner.
 2. The independent review organization shall include in the notice sent pursuant to paragraph (1):
 - a. A general description of the reason for the request for external review;
 - b. The date the independent review organization received the assignment from the Commissioner to conduct the external review;
 - c. The date the external review was conducted;
 - d. The date of its decision;
 - e. The principal reason or reasons for its decision, including what applicable, if any, evidence-based standards were a basis for its decision;
 - f. The rationale for its decision; and
 - g. References to the evidence or documentation, including the evidence-based standards, considered in reaching its decision.

3. Upon receipt of a notice of a decision pursuant to paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.
- J. The assignment by the Commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to Rule 15.12(D) of this Regulation.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

Rule 15.08. Expedited External Review

- A. Except as provided in subsection F, a covered person or the covered person's authorized representative may make a request for an expedited external review with the Commissioner at the time the covered person receives:
 1. An adverse determination if:
 - a. The adverse determination involves a medical condition of the covered person for which the timeframe for completion of an expedited internal review of a grievance involving an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and
 - b. The covered person or the covered person's authorized representative has filed a request for an expedited review of a grievance involving an adverse determination; or
 2. A final adverse determination:
 - a. If the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to Rule 15.07 of this Regulation would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or
 - b. If the final adverse determination concerns an admission, availability of care, continued stay or health care service for which

the covered person received emergency services, but has not been discharged from a facility.

- B.
1. Upon receipt of a request for an expedited external review, the Commissioner immediately shall send a copy of the request to the health carrier.
 2. Immediately upon receipt of the request pursuant to paragraph (1), the health carrier shall determine whether the request meets the reviewability requirements set forth in Rule 15.07(B) of this Regulation. The health carrier shall immediately notify the Commissioner and the covered person and, if applicable, the covered person's authorized representative of its eligibility determination.
 3.
 - a. The Commissioner may specify the form for the health carrier's notice of initial determination under this subsection and any supporting information to be included in the notice.
 - b. The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that an external review request is ineligible for review may be appealed to the Commissioner.
 4.
 - a. The Commissioner may determine that a request is eligible for external review under Rule 15.07(B) of this Regulation notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.
 - b. In making a determination under subparagraph (a) of this paragraph, the Commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this Regulation.
 5. Upon receipt of the notice that the request meets the reviewability requirements, the Commissioner immediately shall assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the Commissioner pursuant to Rule 15.11 of this Regulation. The Commissioner shall immediately notify the health carrier of the name of the assigned independent review organization.
 6. In reaching a decision in accordance with subsection E, the assigned independent review organization is not bound by any decisions or

conclusions reached during the health carrier's utilization review process or the health carrier's internal grievance process.

- C. Upon receipt of the notice from the Commissioner of the name of the independent review organization assigned to conduct the expedited external review pursuant to subsection B(5), the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.
- D. In addition to the documents and information provided or transmitted pursuant to subsection C, the assigned independent review organization, to the extent the information or documents are available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:
 - 1. The covered person's pertinent medical records;
 - 2. The attending health care professional's recommendation;
 - 3. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative or the covered person's treating provider;
 - 4. The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the independent review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;
 - 5. The most appropriate practice guidelines, which shall include evidence-based standards, and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
 - 6. Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review organization in making adverse determinations; and
 - 7. The opinion of the independent review organization's clinical reviewer or reviewers after considering paragraphs (1) through (6) to the extent the information and documents are available and the clinical reviewer or reviewers consider appropriate.
- E.
 - 1. As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than seventy-two (72) hours

after the date of receipt of the request for an expedited external review that meets the reviewability requirements set forth in Rule 15.07(B) of this Regulation, the assigned independent review organization shall:

- a. Make a decision to uphold or reverse the adverse determination or final adverse determination; and
 - b. Notify the covered person, if applicable, the covered person's authorized representative, the health carrier, and the Commissioner of the decision.
2. If the notice provided pursuant to paragraph (1) was not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned independent review organization shall:
- a. Provide written confirmation of the decision to the covered person, if applicable, the covered person's authorized representative, the health carrier, and the Commissioner; and
 - b. Include the information set forth in Rule 15.07(I)(2) of this Regulation.
3. Upon receipt of the notice a decision pursuant to paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.
- F. An expedited external review may not be provided for retrospective adverse or final adverse determinations.
- G. The assignment by the Commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to Rule 15.12(D) of this Regulation.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

Rule 15.09. External Review of Experimental or Investigational Treatment Adverse Determinations

- A. 1. Within four (4) months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Rule 15.04 of

this Regulation that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, a covered person or the covered person's authorized representative may file a request for external review with the Commissioner.

2. a. A covered person or the covered person's authorized representative may make an oral request for an expedited external review of the adverse determination or final adverse determination pursuant to paragraph (1) if the covered person's treating physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.
- b. Upon receipt of a request for an expedited external review, the Commissioner immediately shall notify the health carrier.
- c. i. Upon notice of the request for expedited external review, the health carrier immediately shall determine whether the request meets the reviewability requirements of subsection B. The health carrier shall immediately notify the Commissioner and the covered person and, if applicable, the covered person's authorized representative of its eligibility determination.
- ii. The Commissioner may specify the form for the health carrier's notice of initial determination under item (i) and any supporting information to be included in the notice.
- iii. The notice of initial determination under item (i) shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the Commissioner.
- d. i. The Commissioner may determine that a request is eligible for external review under subsection B(2) notwithstanding a health carrier's initial determination the request is ineligible and require that it be referred for external review.
- ii. In making a determination under item (i), the Commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this Regulation.

- e. Upon receipt of the notice that the expedited external review request meets the reviewability requirements of subsection B(2), the Commissioner immediately shall assign an independent review organization to review the expedited request from the list of approved independent review organizations compiled and maintained by the Commissioner pursuant to Rule 15.11 of this Regulation and notify the health carrier of the name of the assigned independent review organization.
 - f. At the time the health carrier receives the notice of the assigned independent review organization pursuant to subparagraph (e) of this paragraph, the health carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the adverse determination or final adverse determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.
- B.
- 1. Except for a request for an expedited external review made pursuant to subsection A(2), within one (1) business day after the date of receipt of the request, the Commissioner receives a request for an external review, the Commissioner shall notify the health carrier.
 - 2. Within five (5) business days following the date of receipt of the notice sent pursuant to paragraph (1), the health carrier shall conduct and complete a preliminary review of the request to determine whether:
 - a. The individual is or was a covered person in the health benefit plan at the time the health care service or treatment was recommended or requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time the health care service or treatment was provided;
 - b. The recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination:
 - i. Is a covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition; and
 - ii. Is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier;

- c. The covered person's treating physician has certified that one of the following situations is applicable:
 - i. Standard health care services or treatments have not been effective in improving the condition of the covered person;
 - ii. Standard health care services or treatments are not medically appropriate for the covered person; or
 - iii. There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment described in subparagraph (d) of this paragraph;
 - d. The covered person's treating physician:
 - i. Has recommended a health care service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than any available standard health care services or treatments; or
 - ii. Who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person than any available standard health care services or treatments;
 - e. The covered person has exhausted the health carrier's internal grievance process unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to Rule 15.06 of this Regulation; and
 - f. The covered person has provided all the information and forms required by the Commissioner that are necessary to process an external review, including the release form provided under Rule 15.04(B) of this Regulation.
- C. 1. Within one (1) business day after completion of the preliminary review, the health carrier shall notify the Commissioner and the covered person

and, if applicable, the covered person's authorized representative in writing whether:

- a. The request is complete; and
- b. The request is eligible for external review.

2. If the request:

- a. Is not complete, the health carrier shall inform in writing the Commissioner and the covered person and, if applicable, the covered person's authorized representative and include in the notice what information or materials are needed to make the request complete; or
- b. Is not eligible for external review, the health carrier shall inform the covered person, the covered person's authorized representative, if applicable, and the Commissioner in writing and include in the notice the reasons for its ineligibility.

3. a. The Commissioner may specify the form for the health carrier's notice of initial determination under paragraph (2) and any supporting information to be included in the notice.

- b. The notice of initial determination provided under paragraph (2) shall include a statement informing the covered person and, if applicable, the covered person's authorized representative that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the Commissioner.

4. a. The Commissioner may determine that a request is eligible for external review under subsection B(2) notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

- b. In making a determination under subparagraph (a) of this paragraph, the Commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this Regulation.

5. Whenever a request for external review is determined eligible for external review, the health carrier shall notify the Commissioner and the covered person and, if applicable, the covered person's authorized representative.

- D.
1. Within one (1) business day after the receipt of the notice from the health carrier that the external review request is eligible for external review pursuant to subsection A(2)(d) or subsection C(5), the Commissioner shall:
 - a. Assign an independent review organization to conduct the external review from the list of approved independent review organizations compiled and maintained by the Commissioner pursuant to Rule 15.11 of this Regulation and notify the health carrier of the name of the assigned independent review organization; and
 - b. Notify in writing the covered person and, if applicable, the covered person's authorized representative of the request's eligibility and acceptance for external review.
 2. The Commissioner shall include in the notice provided to the covered person and, if applicable, the covered person's authorized representative a statement that the covered person or the covered person's authorized representative may submit in writing to the assigned independent review organization within five (5) business days following the date of receipt of the notice provided pursuant to paragraph (1) additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after five (5) business days.
 3. Within one (1) business day after the receipt of the notice of assignment to conduct the external review pursuant to paragraph (1), the assigned independent review organization shall:
 - a. Select one or more clinical reviewers, as it determines is appropriate, pursuant to paragraph (4) to conduct the external review; and
 - b. Based on the opinion of the clinical reviewer, or opinions if more than one clinical reviewer has been selected to conduct the external review, make a decision to uphold or reverse the adverse determination or final adverse determination.
 4.
 - a. In selecting clinical reviewers pursuant to paragraph (3)(a), the assigned independent review organization shall select physicians or other health care professionals who meet the minimum qualifications described in Rule 15.12 of this Regulation and, through clinical experience in the past three (3) years, are experts in the treatment of the covered person's condition and

knowledgeable about the recommended or requested health care service or treatment.

- b. Neither the covered person, the covered person's authorized representative, if applicable, nor the health carrier shall choose or control the choice of the physicians or other health care professionals to be selected to conduct the external review.
- 5. In accordance with subsection H, each clinical reviewer shall provide a written opinion to the assigned independent review organization on whether the recommended or requested health care service or treatment should be covered.
- 6. In reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during the health carrier's utilization review process or the health carrier's internal grievance process.
- E.
 - 1. Within five (5) business days after the date of receipt of the notice provided pursuant to subsection D(1), the health carrier or its designee utilization review organization shall provide to the assigned independent review organization, the documents and any information considered in making the adverse determination or the final adverse determination.
 - 2. Except as provided in paragraph (3), failure by the health carrier or its designee utilization review organization to provide the documents and information within the time specified in paragraph (1) shall not delay the conduct of the external review.
 - 3.
 - a. If the health carrier or its designee utilization review organization has failed to provide the documents and information within the time specified in paragraph (1), the assigned independent review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.
 - b. Immediately upon making the decision under subparagraph (a) of this paragraph, the independent review organization shall notify the covered person, the covered person's authorized representative, if applicable, the health carrier, and the Commissioner.
- F.
 - 1. Each clinical reviewer selected pursuant to subsection D shall review all of the information and documents received pursuant to subsection E and any other information submitted in writing by the covered person or the covered person's authorized representative pursuant to subsection D(2).

2. Upon receipt of any information submitted by the covered person or the covered person's authorized representative pursuant to subsection D(2), within one (1) business day after the receipt of the information, the assigned independent review organization shall forward the information to the health carrier.
- G.
1. Upon receipt of the information required to be forwarded pursuant to subsection F(2), the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.
 2. Reconsideration by the health carrier of its adverse determination or final adverse determination pursuant to paragraph (1) shall not delay or terminate the external review.
 3. The external review may be terminated only if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the recommended or requested health care service or treatment that is the subject of the adverse determination or final adverse determination.
 4.
 - a. Immediately upon making the decision to reverse its adverse determination or final adverse determination, as provided in paragraph (3), the health carrier shall notify the covered person, the covered person's authorized representative if applicable, the assigned independent review organization, and the Commissioner in writing of its decision.
 - b. The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subparagraph (a) of this paragraph.
- H.
1. Except as provided in paragraph (3), within twenty (20) days after being selected in accordance with subsection D to conduct the external review, each clinical reviewer shall provide an opinion to the assigned independent review organization pursuant to subsection I on whether the recommended or requested health care service or treatment should be covered.
 2. Except for an opinion provided pursuant to paragraph (3), each clinical reviewer's opinion shall be in writing and include the following information:
 - a. A description of the covered person's medical condition;

- b. A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care services or treatments and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;
 - c. A description and analysis of any medical or scientific evidence, as that term is defined in Rule 15.02(DD) of this Regulation, considered in reaching the opinion;
 - d. A description and analysis of any evidence-based standard, as that term is defined in Rule 15.02(S) of this Regulation; and
 - e. Information on whether the reviewer's rationale for the opinion is based on subsection I(5)(a) or (b).
 - 3.
 - a. For an expedited external review, each clinical reviewer shall provide an opinion orally or in writing to the assigned independent review organization as expeditiously as the covered person's medical condition or circumstances requires, but in no event more than five (5) calendar days after being selected in accordance with subsection D.
 - b. If the opinion provided pursuant to subparagraph (a) of this paragraph was not in writing, within forty-eight (48) hours following the date the opinion was provided, the clinical reviewer shall provide written confirmation of the opinion to the assigned independent review organization and include the information required under paragraph (2).
- I. In addition to the documents and information provided pursuant to subsection A(2) or subsection E, each clinical reviewer selected pursuant to subsection D, to the extent the information or documents are available and the reviewer considers appropriate, shall consider the following in reaching an opinion pursuant to subsection H:
 - 1. The covered person's pertinent medical records;
 - 2. The attending physician or health care professional's recommendation;
 - 3. Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, covered person, the covered

person's authorized representative, or the covered person's treating physician or health care professional;

4. The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that, but for the health carrier's determination that the recommended or requested health care service or treatment that is the subject of the opinion is experimental or investigational, the reviewer's opinion is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier; and

5. Whether:

- a. The recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration, if applicable, for the condition; or
- b. Medical or scientific evidence or evidence-based standards demonstrate that the expected benefits of the recommended or requested health care service or treatment is more likely than not to be beneficial to the covered person than any available standard health care service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments.

- J. 1. a. Except as provided in subparagraph (b) of this paragraph, within twenty (20) days after the date it receives the opinion of each clinical reviewer pursuant to subsection I, the assigned independent review organization, in accordance with paragraph (2), shall make a decision and provide written notice of the decision to:

- i. The covered person;
- ii. If applicable, the covered person's authorized representative;
- iii. The health carrier; and
- iv. The Commissioner.

- b. i. For an expedited external review, within forty-eight (48) hours after the date it receives the opinion of each clinical reviewer pursuant to subsection I, the assigned independent review organization, in accordance with paragraph (2), shall make a decision and provide notice of the decision

orally or in writing to the persons listed in subparagraph (a) of this paragraph.

- ii. If the notice provided under item (i) was not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned independent review organization shall provide written confirmation of the decision to the persons listed in subparagraph (a) of this paragraph and include the information set forth in paragraph (3).
- 2.
 - a. If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should be covered, the independent review organization shall make a decision to reverse the health carrier's adverse determination or final adverse determination.
 - b. If a majority of the clinical reviewers recommend that the recommended or requested health care service or treatment should not be covered, the independent review organization shall make a decision to uphold the health carrier's adverse determination or final adverse determination.
 - c.
 - i. If the clinical reviewers are evenly split as to whether the recommended or requested health care service or treatment should be covered, the independent review organization shall obtain the opinion of an additional clinical reviewer in order for the independent review organization to make a decision based on the opinions of a majority of the clinical reviewers pursuant to subparagraph (a) or (b) of this paragraph.
 - ii. The additional clinical reviewer selected under item (i) shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions pursuant to subsection I.
 - iii. The selection of the additional clinical reviewer under this subparagraph shall not extend the time within which the assigned independent review organization is required to make a decision based on the opinions of the clinical reviewers selected under subsection D pursuant to paragraph (1).
 - 3. The independent review organization shall include in the notice provided pursuant to paragraph (1):

- a. A general description of the reason for the request for external review;
 - b. The written opinion of each clinical reviewer, including the recommendation of each clinical reviewer as to whether the recommended or requested health care service or treatment should be covered and the rationale for the reviewer's recommendation;
 - c. The date the independent review organization was assigned by the Commissioner to conduct the external review;
 - d. The date the external review was conducted;
 - e. The date of its decision;
 - f. The principal reason or reasons for its decision; and
 - g. The rationale for its decision.
4. Upon receipt of a notice of a decision pursuant to paragraph (1) reversing the adverse determination or final adverse determination, the health carrier immediately shall approve coverage of the recommended or requested health care service or treatment that was the subject of the adverse determination or final adverse determination.
- K. The assignment by the Commissioner of an approved independent review organization to conduct an external review in accordance with this section shall be done on a random basis among those approved independent review organizations qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including conflict of interest concerns pursuant to Rule 15.12(D) of this Regulation.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

Rule 15.10. Binding Nature of External Review Decision

- A. An external review decision is binding on the health carrier except to the extent the health carrier has other remedies available under applicable State law.
- B. An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or State law.
- C. A covered person or the covered person's authorized representative may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision pursuant to this Regulation.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

Rule 15.11. Approval of Independent Review Organizations

- A. The Commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under this Regulation.
- B. In order to be eligible for approval by the Commissioner under this section to conduct external reviews under this Regulation an independent review organization:
 - 1. Except as otherwise provided in this section, shall be accredited by a nationally recognized private accrediting entity that the Commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations established under Rule 15.12_of this Regulation; and
 - 2. Shall submit an application for approval in accordance with subsection D.
- C. The Commissioner shall develop an application form for initially approving and for reapproving independent review organizations to conduct external reviews.
- D.
 - 1. Any independent review organization wishing to be approved to conduct external reviews under this Regulation shall submit the application form and include with the form all documentation and information necessary for the Commissioner to determine if the independent review organization satisfies the minimum qualifications established under Rule 15.12 of this Regulation.

2.
 - a. Subject to subparagraph (b) of this paragraph, an independent review organization is eligible for approval under this section only if it is accredited by a nationally recognized private accrediting entity that the Commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations under Rule 15.12 of this Regulation.
 - b. The Commissioner may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.
3. The Commissioner may charge an application fee that independent review organizations shall submit to the Commissioner with an application for approval and re-approval.
- E.
 1. An approval is effective for two (2) years, unless the Commissioner determines before its expiration that the independent review organization is not satisfying the minimum qualifications established under Rule 15.12 of this Regulation.
 2. Whenever the Commissioner determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under Rule 15.12 of this Regulation, the Commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this Regulation that is maintained by the Commissioner pursuant to subsection F.
- F. The Commissioner shall maintain and periodically update a list of approved independent review organizations.
- G. The Commissioner may promulgate further rules to carry out the provisions of this section.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

Rule 15.12. Minimum Qualifications for Independent Review Organizations

- A. To be approved under Rule 15.11 of this Regulation to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process

and the expedited external review process set forth in this Regulation that include, at a minimum:

1. A quality assurance mechanism in place that:
 - a. Ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner;
 - b. Ensures the selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this objective;
 - c. Ensures the confidentiality of medical and treatment records and clinical review criteria; and
 - d. Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this Regulation;
 2. A toll-free telephone service to receive information on a 24-hour-day, 7-day-a-week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours; and
 3. Agree to maintain and provide to the Commissioner the information set out in Rule 15.14 of this Regulation.
- B. All clinical reviewers assigned by an independent review organization to conduct external reviews shall be physicians or other appropriate health care providers who meet the following minimum qualifications:
- C.
1. Be an expert in the treatment of the covered person's medical condition that is the subject of the external review;
 2. Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;

3. Hold a non-restricted license in a State of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and
 4. Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical reviewer's physical, mental or professional competence or moral character.
- D. In addition to the requirements set forth in subsection A, an independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, State or local trade association of health benefit plans, or a national, State or local trade association of health care providers.
- E. 1. In addition to the requirements set forth in subsections A, B and C, to be approved pursuant to Rule 15.11 of this Regulation to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or financial conflict of interest with any of the following:
- a. The health carrier that is the subject of the external review;
 - b. The covered person whose treatment is the subject of the external review or the covered person's authorized representative;
 - c. Any officer, director or management employee of the health carrier that is the subject of the external review;
 - d. The health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;
 - e. The facility at which the recommended health care service or treatment would be provided; or
 - f. The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the external review.

2. In determining whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial or financial conflict of interest for purposes of paragraph (1), the Commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial or financial relationship or connection with a person described in paragraph (1), but that the characteristics of that relationship or connection are such that they are not a material professional, familial or financial conflict of interest that results in the disapproval of the independent review organization or the clinical reviewer from conducting the external review.
- F.
1. An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards that the Commissioner has determined are equivalent to or exceed the minimum qualifications of this section shall be presumed in compliance with this section to be eligible for approval under Rule 15.11 of this Regulation.
 2. The Commissioner shall initially review and periodically review the independent review organization accreditation standards of a nationally recognized private accrediting entity to determine whether the entity's standards are, and continue to be, equivalent to or exceed the minimum qualifications established under this section. The Commissioner may accept a review conducted by the NAIC for the purpose of the determination under this paragraph.
 3. Upon request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the Commissioner or the NAIC in order for the Commissioner to determine if the entity's standards are equivalent to or exceed the minimum qualifications established under this section. The Commissioner may exclude any private accrediting entity that is not reviewed by the NAIC.
- G. An independent review organization shall be unbiased. An independent review organization shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this section.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

Rule 15.13. Hold Harmless for Independent Review Organization

No independent review organization or clinical reviewer working on behalf of an independent review organization or an employee, agent or contractor of an independent review organization shall be liable in damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to this Regulation, unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

Rule 15.14. External Review Reporting Requirements

- A.
 1. An independent review organization assigned pursuant to Rule 15.07, Rule 15.08 or Rule 15.09 of this Regulation to conduct an external review shall maintain written records in the aggregate by State and by health carrier on all requests for external review for which it conducted an external review during a calendar year and, upon request, submit a report to the Commissioner, as required under paragraph (2).
 2. Each independent review organization required to maintain written records on all requests for external review pursuant to paragraph (1) for which it was assigned to conduct an external review shall submit to the Commissioner, upon request, a report in the format specified by the Commissioner. The Independent Review Organization External Review Annual Report Form attached hereto as Rule 15.22 - Appendix "C" meets all form and content requirements of this section.
 3. The report shall include in the aggregate by State, and for each health carrier:
 - a. The total number of requests for external review;
 - b. The number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination;
 - c. The average length of time for resolution;
 - d. A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the Commissioner;
 - e. The number of external reviews pursuant to Rule 15.07(G) of this Regulation that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse

determination after the receipt of additional information from the covered person or the covered person's authorized representative; and

- f. Any other information the Commissioner may request or require.
- 4. The independent review organization shall retain the written records required pursuant to this subsection for at least three (3) years.
- B.
 - 1. Each health carrier shall maintain written records in the aggregate, by State and for each type of health benefit plan offered by the health carrier on all requests for external review that the health carrier receives notice of from the Commissioner pursuant to this Regulation.
 - 2. Each health carrier required to maintain written records on all requests for external review pursuant to paragraph (1) shall submit to the Commissioner, upon request, a report in the format specified by the Commissioner. The Health Carrier External Review Annual Report Form Attached hereto as Rule 15.23 - Appendix "D" meets all form and content requirements of this section.
 - 3. The report shall include in the aggregate, by State, and by type of health benefit plan:
 - a. The total number of requests for external review;
 - b. From the total number of requests for external review reported under subparagraph (a) of this paragraph, the number of requests determined eligible for a full external review; and
 - c. Any other information the Commissioner may request or require.
 - 5. The health carrier shall retain the written records required pursuant to this subsection for at least three (3) years.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

Rule 15.15. Funding of External Review

The health carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost of the independent review organization for conducting the external review.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

Rule 15.16. Disclosure Requirements

- A.
 - 1. Each health carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to covered persons.
 - 2. The disclosure required by paragraph (1) shall be in a format approved by the Commissioner.
- B. The description required under subsection A shall include a statement that informs the covered person of the right of the covered person to file a request for an external review of an adverse determination or final adverse determination with the Commissioner. The statement may explain that external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care or effectiveness. The statement shall include the telephone number and address of the Commissioner.
- C. In addition to subsection B, the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

Rule 15.17. Filing of Forms

Any forms issued by a health carrier to the covered person or the covered person's authorized representative pursuant to this regulation must be filed with and approved by the Commissioner prior to use.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

Rule 15.18. Severability

If any provision of this Regulation, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Regulation, and the application of 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 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

Rule 15.19. Effective Date

This Regulation shall be effective on January 1, 2013.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

Rule 15.20: Appendix A – Notice of Appeal Rights

NOTICE OF APPEAL RIGHTS

You have a right to appeal any decision we make that denies payment on your claim or your request for coverage of a health care service or treatment.

You may request more explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered. Contact¹ us when you:

- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;
- Cannot find the applicable provision in your Benefit Plan Document;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and you want to appeal.

If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim.

Appeals: All appeals for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent to [insert address of where appeals should be sent to the health carrier] within **180 days** of the date you receive our denial.² We will provide a full and fair review of your claim by individuals associated with us, but who were not involved in making the initial denial of your claim. You may provide us with additional information that relates to your claim and you may request copies of information that we have that pertains to your claims. We will notify you of our decision in writing within **60 days** of receiving your appeal.³ If you do not receive our decision within **60 days** of receiving your appeal, you may be entitled to file a request for external review.⁴

External Review⁴: We have denied your request for the provision of or payment for a health care service or course of treatment. You may have a right to have our decision reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested by submitting a request for external review within **4 months** after receipt of this notice to the Office of the Insurance Commissioner, Mississippi Insurance Department, Attn: Life and Health Actuarial Division, P.O. Box 79, Jackson, MS 39205, Phone: (601) 359-3569. For standard external review, a decision will be made within **45 days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of our denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigation, you also may be entitled to file a request for external review of our denial. For details, please review your Benefit Plan Document, contact us or contact your state insurance department.¹

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

¹ See address and telephone number on the enclosed Explanation of Benefits if you have questions about this notice.

² Unless your plan or any applicable state law allows you additional time.

³ Some states and plans allow you more (or less) time to file an appeal and less (or more) time for our decision. See your Benefit Plan Document for your state's appeal process.

⁴ See your Benefit Plan Document for your state's appeal process and to determine if you're eligible to request an external review in your state (e.g. some state appeal processes require you to complete your insurer's appeal process before filing an external review request unless waived by your insurer; while some states do not have such a requirement).

Rule 15.21: Appendix B – External Review Request Form

This **EXTERNAL REVIEW REQUEST FORM** must be filed with Mississippi Insurance Department within **FOUR (4) MONTHS** after receipt from your insurer of a denial of payment on a claim or request for coverage of a health care service or treatment.

EXTERNAL REVIEW REQUEST FORM

APPLICANT NAME: _____ ☐ Covered person/Patient ☐ Provider ☐
☐ Authorized Representative

COVERED PERSON/PATIENT INFORMATION

Covered Person Name: _____ Patient Name: _____

Address: _____

Covered Person Phone #: Home (_____) _____

Work (_____) _____

INSURANCE INFORMATION

Insurer/HMO

Name: _____

Covered Person Insurance ID#:

Insurance Claim/Reference

#: _____

Insurer/HMO Mailing Address:

Insurer Telephone

#: (_____) _____

EMPLOYER INFORMATION

Employer's

Name: _____

Employer's Phone

#: (_____) _____

Is the health coverage you have through your employer a self-funded plan? _____. If you are not certain please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may voluntarily provide external review, but may have different procedures. You should check with your employer.

HEALTH CARE PROVIDER INFORMATION

Treating Physician/Health Care Provider:

Address:

Contact Person: _____ Phone: () _____

Medical Record #: _____

REASON FOR HEALTH CARRIER DENIAL (Please check one)

☐ The health care service or treatment is not medically necessary.

☐ The health care service or treatment is experimental or investigational.

SUMMARY OF EXTERNAL REVIEW REQUEST (Enter a brief description of the claim, the request for health care service or treatment that was denied, and/or attach a copy of the denial from your health carrier)*

*You may also describe in your own words the health care service or treatment in dispute and why you are appealing this denial using the attached pages below.

EXPEDITED REVIEW

If you need a fast decision, you may request that your external appeal be handled on an expedited basis. To complete this request, your treating health care provider must fill out the attached form stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.

Is this a request for an expedited appeal? Yes _____ No _____

SIGNATURE AND RELEASE OF MEDICAL RECORDS

To appeal your health carrier's denial, you must sign and date this external review request form and consent to the release of medical records.

I, _____, hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize by insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the Mississippi Insurance Department. I understand that the independent review organization and the Mississippi Insurance Department will use this information to make a determination on my external appeal and that the information will be kept confidential and not be released to anyone else. This release is valid for one year.

Signature of Covered Person (or legal representative)*

*(Parent, Guardian, Conservator or Other – Please Specify)

Date

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

(Fill out this section only if someone else will be representing you in this appeal.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

Signature of Covered Person (or legal representative)*

Date

*(Parent, Guardian, Conservator or Other—Please Specify)

Address of Authorized Representative:

Phone #: Daytime(_____) _____ Evening(_____) _____

HEALTH CARE SERVICE OR TREATMENT DECISION IN DISPUTE

DESCRIBE IN YOUR OWN WORDS THE DISAGREEMENT WITH YOUR HEALTH CARRIER. INDICATE CLEARLY THE SERVICE(S) BEING DENIED AND THE SPECIFIC DATE(S) BEING DENIED. EXPLAIN WHY YOU DISAGREE. ATTACH ADDITIONAL PAGES IF NECESSARY AND INCLUDE AVAILABLE PERTINENT MEDICAL RECORDS, ANY INFORMATION YOU RECEIVED FROM YOUR HEALTH CARRIER CONCERNING THE DENIAL, ANY PERTINENT PEER LITERATURE OR CLINICAL STUDIES, AND ANY ADDITIONAL INFORMATION FROM YOUR PHYSICIAN/HEALTH CARE PROVIDER THAT YOU WANT THE INDEPENDENT REVIEW ORGANIZATION REVIEWER TO CONSIDER.

[illegible]

WHAT TO SEND AND WHERE TO SEND IT

PLEASE CHECK BELOW (NOTE: YOUR REQUEST WILL NOT BE ACCEPTED FOR FULL REVIEW UNLESS ALL FOUR (4) ITEMS BELOW ARE INCLUDED*)

1. ☐ ☐ **YES**, I have included this completed application form signed and dated.
2. ☐ ☐ **YES**, I have included a photocopy of my insurance identification card or other evidence showing that I am insured by the health insurance company named in this application;
3. ☐ ☐ **YES****, I have enclosed the letter from my health carrier or utilization review company that states:
 - (a) Their decision is final and that I have exhausted all internal review procedures; or
 - (b) They have waived the requirement to exhaust all of the health carrier's internal review procedures.

**You may make a request for external review without exhausting all internal review procedures under certain circumstances. You should contact the Office of the Insurance Commissioner, Mississippi Insurance Department, Attn: Life and Health Actuarial Division, P.O. Box 79, Jackson, MS 39205, Phone: (601) 359-3569.

4. ☐ ☐ **YES**, I have included a copy of my certificate of coverage or my insurance policy benefit booklet, which lists the benefits under my health benefit plan.

*Call the Insurance Department at (601) 359-3569 if you need help in completing this application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for external review.

If you are requesting a standard external review, send all paperwork to: Mississippi Insurance Department, Attn: Life and Health Actuarial Division, P.O. Box 79, Jackson, MS 39205

If you are requesting an expedited external review, call the Insurance Department before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.

**CERTIFICATION OF TREATING HEALTH CARE PROVIDER
FOR EXPEDITED CONSIDERATION OF A PATIENT'S EXTERNAL REVIEW APPEAL**

NOTE TO THE TREATING HEALTH CARE PROVIDER

Patients can request an external review when a health carrier has denied a health care service or course of treatment on the basis of a utilization review determination that the requested health care service or course of treatment does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. The Mississippi Insurance Department oversees external appeals. The standard external review process can take up to 45 days from the date the patient's request for external review is received by our department. Expedited external review is available only if the patient's treating health care provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. An expedited external review must be completed at most within 72 hours. This form is for the purpose of providing the certification necessary to trigger expedited review.

GENERAL INFORMATION

Name of Treating Health Care Provider:_____

Mailing Address:

Phone Number:(_____)_____ Fax Number:(_____)_____

Licensure and Area of Clinical Specialty:_____

Name of Patient:_____

Patient's Insurer Member ID#:_____

CERTIFICATION

I hereby certify that: I am a treating health care provider for

(hereafter referred to as "the patient"); that adherence to the time frame for conducting a standard external review of the patient's appeal would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and that, for this reason, the patient's appeal of the denial by the patient's health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

Treating Health Care Provider's Name: (Please Print)

Signature

Date

**PHYSICIAN CERTIFICATION
EXPERIMENTAL/INVESTIGATIONAL DENIALS
(To Be Completed by Treating Physician)**

I hereby certify that I am the treating physician for _____ (covered person's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the insurance company's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person to obtain the right to an external review of this denial, as treating physician I must certify that the covered person's medical condition meets certain requirements:

In my medical opinion as the Insured's treating physician, I hereby certify to the following:

(Please check all that apply) (NOTE: Requirements #1 - #3 below must all apply for the covered person to qualify for an external review).

- ☐ 1) The covered person has a terminal medical condition, life threatening condition, or a seriously debilitating condition.
- ☐ 2) The covered person has a condition that qualifies under one or more of the following:

[please indicate which description(s) apply]:
 - ☐ Standard health care services or treatments have not been effective in improving the covered person's condition;
 - ☐ Standard health care services or treatments are not medically appropriate for the covered person; or
 - ☐ There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment.
- ☐ 3) The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the covered person than any available standard health care services or treatments.
- ☐ 4) The health care service or treatment recommended would be significantly less effective if not promptly initiated.

Explain: _____

- ☐ ☐ 5) It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the covered person and which has been denied is likely to be more beneficial to the covered person than any available standard health care services or treatments.

Explain:

Please provide a description of the recommended or requested health care service or treatment that is the subject of the denial. (Attach additional sheets as necessary)

Physician's Signature

Date

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

Rule 15.22: Appendix C – Independent Review Organization External Review Annual Report Form

Mississippi Insurance Department

Independent Review Organization External Review Annual Report Form

External Review Annual Summary for 20_____	
Due on [insert date] for previous calendar year.	
Each independent review organization (IRO) shall submit an annual report with information for each health carrier in the aggregate on external reviews performed in Mississippi only.	
1. IRO name:_____	Filing date:_____
2. IRO license/certification no: _____	
3. IRO address:_____	
City, State, ZIP: _____	
IRO Web site: _____	
4. Name, email address, phone and fax number of the person completing this form: _____ _____	
5. Name and title of the person responsible for regulatory compliance and quality of external reviews: Name: _____ Title: _____	
6. Total number of requests for external review received from Mississippi Insurance Department during the reporting period: _____	
7. Number of standard external reviews: _____	
8. Average number of days IRO required to reach a final decision in standard reviews:	_____
9. Number of expedited reviews completed to a final decision: _____	
10. Average number of days IRO required to reach a final decision in expedited reviews: _____	
11. Number of medical necessity reviews decided in favor of the health carrier: _____	

Briefly list procedures denied:_____	
12. Number of medical necessity reviews decided in favor of the covered person:_____	
Briefly list procedures approved:	_____ _____ _____ _____
13. Number of experimental/investigational reviews decided in favor of the health carrier:_____	
Briefly list procedures denied:	_____ _____ _____ _____
14. Number of experimental/investigational reviews decided in favor of the covered person:_____	
Briefly list procedures approved:	_____ _____ _____
15. Number of reviews terminated as the result of a reconsideration by the health carrier:_____	
16. Number of reviews terminated by the covered person:_____	
18. Number of reviews declined due to possible conflict with:	
Health carrier_____	Covered person_____ Health care provider_____
Describe possible conflicts(s) of interest:_____	
19. Number of reviews declined due to other reasons not reflected in #18 above:_____	

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

Rule 15.23: Appendix D – Health Carrier External Review Annual Report Form

Mississippi Insurance Department Health Carrier External Review Annual Report Form

External Review Annual Summary for 20_____	
Due on [insert date] for previous calendar year.	
Each health carrier shall submit an annual report with information in the aggregate by State and by type of health benefit plan.	
1. Health carrier name:_____	Filing Date:_____
2. Health carrier address:_____ City, State, ZIP:_____	
3. Health carrier Web site:_____	
4. Name, email address, phone and fax number of the person completing this form: _____ _____	
5. Total number of external review requests received from Mississippi Insurance Department during the reporting period:_____	
6. From the total number of external review requests provided in Question 5, the number of requests determined eligible for a full external review:_____	

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011); Public Law 111-148-Mar. 23, 2010 (Patient Protection and Affordable Care Act)

Title 19 Mississippi Administrative Code, Part 3, Chapter 16: Form and Manner of Notices When Renewing a Product in the Individual Market.

Rule 16.01: Authority

This regulation is adopted and promulgated pursuant to the authority granted by *Miss. Code Ann.* Section 83-5-1 (Rev. 2011), and in accordance with the provisions of the Administrative Procedures Act found at *Miss Code Ann.* 25-43-1, et seq., and the Mississippi Insurance Department Regulation 19 Miss. Admin. Code, Part 1, Chapter 15, said regulation being the “Rules of Practice and Procedure before the Mississippi Insurance Department”.

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

Rule 16.02: Purpose

The Centers for Medicare and Medicaid Services (CMS) issued a Bulletin entitled *Form and Manner of Notices when Discontinuing or Renewing a Product in the Small Group or Individual Market* on September 2, 2014. Under 45 CFR Sections 146.152, 147.106, and 148.122 an issuer that discontinues or renews a particular individual product must provide notice of such discontinuation or renewal in a form and manner specified by the Secretary of Health and Human Services. States that are enforcing the Affordable Care Act may, without obtaining further approval from CMS, develop their own notice for renewal, provided the State-developed notice is at least as protective as the Federal standard notice. The purpose and intent of this regulation is to provide issuers with a State-developed renewal notice to be used when renewing an individual product.

Source: 45 CFR §§ 146.152, 147.106, and 148.122; Miss. Code Ann. § 83-5-1 (Rev. 2011).

Rule 16.03: Adoption of a Mississippi Renewal Form for Individual Products

In accordance with CMS guidance, the Mississippi Department of Insurance (“Department”) has created a form entitled “Renewal Form for Individual Products” (“Form”), which is found in Rule 16.06 of this Regulation. Issuers may begin using this form immediately, without the necessity of obtaining prior approval from the Department. Minor non-substantive changes which identify the issuer or which provide contact information are allowed. Material changes or additions to the form are not allowed.

Source: 45 CFR §§ 146.152, 147.106, and 148.122; Miss. Code Ann. § 83-5-1 (Rev. 2011).

Rule 16.04: Severability Clause

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

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

Rule 16.05: Effective Date

This Regulation shall be effective thirty (30) days after final adoption with the Office of the Secretary of State.

Source: Miss. Code Ann. §§ 25-43-3.108; 25-43-3.112; 83-5-1 (Rev. 2011).

Rule 16.06: Renewal Form for Individual Products

**RENEWAL FORM FOR INDIVIDUAL PRODUCTS OFFERED OUTSIDE OF
THE MARKETPLACE**

Important: We are continuing to Offer Your Health Coverage.
--

Dear (First Name of Subscriber):

Your health insurance coverage is coming up for renewal. **On (Date of Renewal), you will be automatically re-enrolled and can keep your current coverage. If you do not want to be automatically re-enrolled, you need to contact (Insurer's Name) by (Date).**

Each year, insurance companies can make changes to the plans and coverage options they offer. You can find these changes, if any, in Attachment A along with your monthly premium (Note: Insurer should add changes to the Insured's coverage in the attachment which includes monthly premium and benefit plan changes. Insurers providing this notice electronically may refer to a tab that would contain monthly premium and benefit changes).

Please note your current plan is not offered by (Insurer's Name) through the Marketplace. This plan does not allow you to receive financial assistance to lower your monthly premiums or lower your out-of-pockets costs.

What if I want to look into other plans? You have three ways to look into other plans and enroll.

- The (Plan Year) Open Enrollment period for the Marketplace is from (Enrollment Period). If you want a new plan with coverage that starts on January 1, 20____ in the Marketplace, the deadline to enroll is (Deadline Date). Visit HealthCare.gov and look at other Marketplace plans.
- Visit HealthCare.gov and see if you qualify or your family qualifies for Medicaid or the Children's Health Insurance Program (CHIP).
- Look at other plans outside of the Marketplace. Just keep in mind that if you qualify for financial assistance to lower your monthly or out-of-pocket costs, you can only get these savings if you enroll through Healthcare.gov.

What else should I look at before deciding to keep or change my plan?

Call (Name of Insurer) at (Insurer's phone number) or visit (Name of Insurer) website to make sure your doctor and other health care providers will be in the plan network next year. Also check to make sure any prescription medications you take will be covered (This provision is optional. Insurer may elect to delete this provision).

Questions?

- Call (Name of Insurer) at (Insurer's phone number) or visit (Insurer's website). You can also work with a licensed insurance agent or broker.
- Visit HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325) to learn more about the Health Insurance Marketplace.

Getting Help in Other Languages

English: For help in (Language) call (Phone number) and an interpreter will assist you with this notice at no cost.

SPANISH (Espanol): Para obtener asistencia en Espanol, llame al (Phone Number)

Source: 45 CFR §§ 146.152, 147.106, and 148.122; Miss. Code Ann. § 83-5-1 (Rev. 2011).

Part 3 Chapter 17: Large Group Health Insurance Claims Data Reporting

Rule 17.01 Authority

This regulation is adopted and promulgated pursuant to the authority granted by Miss. Code Ann. § 83-5-1, §§ 83-9-1 et seq., §§ 83-41-401 et seq. and in accordance with the provisions of the Administrative Procedures Act found at Miss Code Ann. § 25-43-1 et seq.

Source: Miss. Code Ann. §§ 25-43-1 et seq.; § 83-5-1; §§ 83-9-1 et seq., § 83-41-401, et seq. (Rev. 2011).

Rule 17.02 Purpose and Scope

- A. Purpose. The purpose of this regulation is to establish requirements for companies who offer fully insured, comprehensive, major medical health insurance products on the remittance of certain claims data to large employer groups as defined by Mississippi Insurance Department Bulletin 2016-9, entitled, “Clarification on How and When Employees Must be Counted for the Purposes of Determining Group Health Plan Size.”
- B. Scope. This regulation shall apply to all health carriers that offer managed care plans.

Source: Miss. Code Ann. § 83-5-1; §§ 83-9-1 et seq., § 83-41-405; § 83-41-413 (Rev. 2011).

Rule 17.03 Claims Data Reporting

- A. Upon request by a large employer group (“group”) or the group’s agent or broker, the group’s health carrier shall make available the currently available summary health information, aggregate paid claims, and premium data accumulated for the current and the immediately preceding policy periods. The company shall make this data available within ten (10) business days of the request.
- B. The company may condition the remittance of the data on both the execution of an agreement for immunity from civil liability and a certification of compliance with the federal rules concerning privacy of individually identifiable health information found in 45 C.F.R. Section 164.504(f)(2).

- C. All group claims data reports provided pursuant to this regulation shall include all data available to the company as of the date of the request and shall include the following information:
1. The net claims paid by month during the current and the immediately preceding policy period.
 2. The monthly enrollment by employee only, employee and spouse, employee and child(ren), and the employee and family during the current and the immediately preceding policy period.
 3. The amount of any claims reserve established by the insurance company against future claims under the policy, to the extent the company maintains claims reserves on a group policyholder basis.
 4. Claims over twenty-five thousand dollars (\$25,000.00) including claim identifier, the date of occurrence, the amount of claims paid and those unpaid or outstanding, and claimant health condition or diagnosis during the current and the immediately preceding policy period. The data shall provide a unique identifying number or code for the claimant.
- D. Nothing in this section shall be construed to prohibit a plan and group from negotiating the release of additional information not described in this regulation.
- E. The provisions of this regulation shall not be construed to authorize the disclosure of the identity of a particular employee covered under the group policy, nor the disclosure of any individual employee's particular health insurance claim, condition, diagnosis, or prognosis, which would violate federal or state law. Nothing in this regulation shall be construed to require an insurer to provide information protected as confidential by the Health Insurance Portability and Accountability Act of 1996 or any other provision of federal law.

Source: Miss. Code Ann. § 83-5-1, §§ 83-9-1 et seq., §§ 83-41-401 et seq. (Rev. 2011).

Rule 17.04: Severability

If any section or portion of a section of this regulation or the application thereof to any person or circumstance is held by a court to be invalid, such invalidity shall not affect any other provision of that section or application of this 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 (Rev. 2011).

Rule 17.05: Effective Date

This regulation shall become effective thirty (30) days after filing for final adoption with the Office of the Secretary of State.

Source: *Miss. Code Ann.* § 25-43-3.112; § 25-43-3.113 (Rev. 2018).

Title 19, Part 3, Chapter 18: Managed Care Plan Certification Regulation

Rule 18.01. Title

This Regulation shall be known and may be cited as the Managed Care Plan Certification Regulation and is promulgated by the Commissioner of Insurance pursuant to the authority granted to him by Title 83, the Mississippi Insurance Code; the requirements of *Miss. Code Ann.* §§ 25-43-1.101, et seq., the Mississippi Administrative Procedures Law; and the requirements of *Miss. Code Ann.* §§ 83-41-401, et seq., the Mississippi Patient Protection Act of 1995.

Source: *Miss. Code Ann.* §§ 25-43-1.101, et seq.; § 83-5-1; §§ 83-41-401, et seq. (Rev. 2022)

Rule 18.02. Purpose

The purpose of this Regulation is to establish a process for certifying managed care plans pursuant to the provisions of *Miss. Code Ann.* §§ 83-41-401 et seq., also known as the Mississippi Patient Protection Act of 1995. Additionally, it furthers the goals of the Managed Care Plan Network Adequacy Regulation, Title 19, Part 3, Chapter 14, by requiring that managed care plans have adequate networks in order to be certified by the Mississippi Insurance Department.

Source: *Miss. Code Ann.* § 83-41-405; § 83-41-413 (Rev. 2022)

Rule 18.03. Definitions

For purposes of this Regulation, the term “managed care entities” as used herein, shall include a “health carrier” as that term is defined in Rule 14.03 of Title 19, Part 3, Chapter 14. Any term defined in Rule 14.03 of Title 19, Part 3, Chapter 14 will have the same meaning in this Chapter 18. Further, any terms defined in *Miss. Code Ann.* § 83-41-403 (Rev. 2022) shall have the same meaning in this Chapter 18.

Source: *Miss. Code Ann.* § 83-41-403; § 83-41-405; § 83-41-413 (Rev. 2022)

Rule 18.04. Applicability and Scope

This Regulation shall apply to all managed care plans, managed care entities and managed care contractors; provided, however, the Regulation shall not apply to the Mississippi State Employee Health Plan or to any managed care plan regulated by the Mississippi Division of Medicaid.

Source: *Miss. Code Ann.* § 83-41-405; § 83-41-413 (Rev. 2022)

Rule 18.05. Filing Requirements and State Administration

- A. Beginning January 1, 2025, managed care entities shall file with the Commissioner sample contract forms proposed for use with its participating providers and intermediaries.
- B. By June 1 of each calendar year, managed care entities shall submit to the Commissioner, in an electronic format (such as Excel) that is readily useable by the Department, a complete list, effective January 1 of that calendar year, of: (1) the names of its Participating Providers; (2) each Participating Provider's most closely-affiliated type as provided for in Rule 14.05; (3) the complete practice location address for each Participating Provider; and (4) contact information for each Participating Provider.
- C. By June 1 of each calendar year, managed care entities shall submit to the Commissioner, in electronic format (such as Excel) that is readily useable by the Department, a complete list, effective January 1 of that calendar year, of: (1) the names of its covered persons; and (2) the complete residential addresses of each covered person.
- D. By June 1 of each calendar year, managed care entities shall submit to the Commissioner a certification attestation in the following format: "I attest that [managed care entity] has complied with the Managed Care Plan Network Adequacy Regulation and the Managed Care Plan Certification Regulation promulgated by the Mississippi Department of Insurance." If a managed care entity is unable to meet compliance with any rules in those Regulations, including, but not limited to, Rule 14.05(B), Rule 14.05(C) and Rule 14.05(D), such attestation shall include reasons why the carrier contends it was unable to meet such standards and why the Commissioner should give special consideration to the reasons asserted for lack of compliance.
- E. By June 1 of each calendar year, managed care entities shall submit to the Commissioner a complete, detailed description of their measures to provide covered persons, in easily understandable language, written information on the terms and conditions of coverage, including:
- (1) coverage provisions;
 - (2) benefits;
 - (3) limitations;
 - (4) exclusions and restrictions on the use of any providers of care;
 - (5) a summary of utilization review and quality assurance policies;

- (6) enrollee financial responsibility for copayments, deductions, and payment for out-of-plan services and supplies;
- (7) the managed care entity's policies, in circumstances where the managed care entity has an insufficient number or type of participating providers/facilities to provide a covered benefit consistent with the geographic access standards set forth in the Managed Care Network Adequacy Regulation, Section 14.05(B), or fails to provide a covered benefit consistent with the geographic access standards set forth in Section 14.05(B), to ensure covered persons obtain the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, and to ensure in such situations, the provision of covered persons with reasonable reimbursement for the covered persons travel, lodging, and incidental expenses as set forth in the Managed Care Network Adequacy Regulation, Rule 14.05(C);
- (8) a summary of the managed care entity's credentialing criteria and process and policies relating to the credentialing criteria;
- (9) the managed care entity's procedures for ensuring a provider may request a copy of the provider's individual profile if economic or practice profiles, or both, are used in the credentialing process;
- (10) the managed care entity's procedures for ensuring a provider is aware that the provider may request to review the reasons for denial or termination with regard to a provider's application that has been denied or where the provider's contract is terminated;
- (11) the managed care entity's procedure/policy to ensure adherence with all applicable state and federal laws designed to protect the confidentiality of medical records; and
- (12) the managed care entity's procedures to ensure interested healthcare providers within the geographic area of the managed care entity's network are given an opportunity to apply for participation.

Source: *Miss. Code Ann.* § 83-41-405; § 83-41-413 (Rev. 2022)

Rule 18.06. Certification and Enforcement

A. Based on the information managed care entities must submit pursuant to this Regulation and the Managed Care Network Adequacy Regulation, the Commissioner shall review such information and if found sufficient, the Commissioner shall issue an annual certification of each managed care plan. Such certification shall allow the managed care entity's continued operation of the managed care plan except that such

certification shall always be subject to reconsideration should the Commissioner determine, in his or her sole discretion, that the managed care entity has not in fact complied with the requirements of this Regulation.

B. If the Commissioner determines that a managed care entity has not sufficiently complied with any provision of the Managed Care Network Adequacy Regulation or this Regulation, the Commissioner may institute a corrective action that shall be followed by the managed care entity, may deny certification of the managed care entity's plan, or may use any of the Commissioner's other enforcement powers to obtain the managed care entity's compliance.

C. If the Commissioner determines that a managed care entity's network does not sufficiently comply with the Managed Care Network Adequacy Regulation or this Regulation, the Commissioner shall afford a managed care entity a hearing, consistent with Mississippi Department of Insurance regulations, upon a managed care entity's request made within twenty (20) days of notification of the Commissioner's determination, before such determination becomes final.

Source: *Miss. Code Ann.* § 83-41-405; § 83-41-413 (Rev. 2022)

Rule 18.07. Ongoing Compliance

The Commissioner, at any time, may review a managed care entity's compliance with this Regulation or the Managed Care Plan Network Adequacy Regulation, request information from the managed care entity necessary to investigate the managed care entity's compliance, and order the corrective measures the Commissioner, in his or her sole discretion, deems necessary. The Commissioner may retain outside consultants to assist in such review if the Commissioner determines such is appropriate, and the fees and costs of such consultants' services shall be paid by the managed care entity to the consultants pursuant to *Miss. Code Ann.* § 83-41-407.

Source: *Miss. Code Ann.* § 83-41-405; § 83-41-407; § 83-41-411, and § 83-41-413 (Rev. 2022)

Rule 18.08. Confidentiality

A managed care entity or managed care contractor may designate material submitted to the Commissioner pursuant to this regulation as confidential and exempt from disclosure to the public under the Mississippi Public Records Act if the health carrier deems the material to meet the criteria set forth in *Miss. Code Ann.* § 25-61-9(1).

Source: *Miss. Code Ann.* § 25-61-9; § 83-41-43 (Rev. 2022)

Rule 18.09. Penalties

A violation of this Regulation shall be subject to the penalty provisions set forth in *Miss. Code Ann.* § 83-5-17, as well as other penalty provisions under applicable law.

Source: *Miss. Code Ann.* § 83-5-17; § 83-41-405; § 83-41-413 (Rev. 2022)

Rule 18.10. Severability

If any provision of this Regulation, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Regulation, and the application of 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. 2022)

Rule 18.11. Effective Date

This Regulation shall be effective thirty (30) days after final adoption with the Office of the Secretary of State. All provider and intermediary contracts in effect on the effective date of this Regulation, or which are issued or put in force on or after the effective date of this Regulation, shall comply with this Regulation no later than January 1, 2025. The Commissioner may extend this deadline for an additional period not to exceed six (6) months if the managed care entity demonstrates good cause for an extension.

Source: *Miss. Code Ann.* § 25-43-3.112 (Rev. 2022)

Title 19, Part 3, Chapter 19: Minimum Standards for Utilization Review Agents Regulation

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Rule 19.01 Title

This Regulation shall be known and may be cited as the Utilization Review Regulation and is promulgated by the Commissioner of Insurance pursuant to the authority granted to him by Title 83, the Mississippi Insurance Code; the requirements of *Miss. Code Ann.* §§ 25-43-1.101 et seq., the Mississippi Administrative Procedures Law; and the requirements of *Miss. Code Ann.* §§ 83-5-901 through 83-5-937, the Mississippi Prior Authorization Reform Act.

Source: *Miss. Code Ann.* §§ 25-43-1.101, et seq.; § 83-5-1; § 41-83-1, et seq.; *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.02. Purpose

The purpose of these rules and regulations is to promote the delivery of quality health care in a cost effective manner; foster greater coordination between payors and providers conducting utilization review activities; protect patients, business and providers by ensuring that private review agents are qualified to perform utilization activities and to make informed decisions on the appropriateness of medical care; and to ensure that private review agents maintain the confidentiality of medical records.

Source: *Miss. Code Ann.* §41-83-1, et seq. (Rev. 2023); *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.03 Definitions

Unless otherwise defined herein, any term defined in *Miss. Code Ann.* §§ 83-5-901 through 83-5-937 shall have the same meaning in this Regulation.

Source: *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.04 Applicability and Scope

This Regulation shall apply to every health insurance issuer and all health benefit plans, as both terms are defined in *Miss. Code Ann.* § 83-9-6.3, and all private review agents and utilization

review plans, as both terms are defined in *Miss. Code Ann.* § 41-83-1, with the exception of employee or employer self-insured health benefit plans under the federal Employee Retirement Income Security Act of 1974 or health care provided pursuant to the Workers' Compensation Act. This act does not diminish the duties and responsibilities under other federal or state law or rules promulgated under those laws applicable to a health insurer, health insurance issuer, health benefit plan, private review agent or utilization review plan, including, but not limited to, the requirement of a certificate in accordance with *Miss. Code Ann.* §41-83-3.

For simplification, when the term “health insurance issuer” is used alone in these Regulations, the term also includes health benefit plans, private review agents and utilization review plans unless otherwise explicitly stated.

(1) In the State of Mississippi, every health insurance plan or every insurer proposing to issue or deliver a health insurance policy or contract or administer a health benefit program which provides for the coverage of hospital and medical benefits and the utilization review of those benefits; every health insurer proposing to issue or deliver in this state a group or blanket health insurance policy or administer a health benefit program which provides for the coverage of hospital and medical benefits and the utilization review of such benefits shall:

- a. Have a certificate in accordance with these regulations;
- b. Contract with a private review agent that has a certificate in accordance with these regulations.

(2) Notwithstanding any provisions of these regulations, for claims where medical necessity of the provision of a covered benefit is disputed, an insurer that does not meet the requirements of this section shall pay any person or hospital entitled to reimbursement under the policy or contract.

Source: *Miss. Code Ann.* §41-83-1, et seq. (Rev. 2023);-*Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.05 Definitions

- (1) **Adverse determination:** A determination by a health insurance issuer that, based on the information provided, a request for a benefit under the health insurance issuer's health benefit plan upon application of any utilization review technique does not meet the health insurance issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit; the denial, reduction, or termination of or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health insurance issuer that a preexisting condition was present before the effective date of coverage; or a rescission of coverage determination, which does not include a

cancellation or discontinuance of coverage that is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

- (2) **Appeal:** A formal request, either orally or in writing, to reconsider an adverse determination.
- (3) **Approval:** A determination by a health insurance issuer that a health care service has been reviewed and, based on the information provided, satisfies the health insurance issuer's requirements for medical necessity and appropriateness.
- (4) **Attending Physician:** The physician with primary responsibility for the care provided to a patient in a hospital or other health care facility.
- (5) **Certificate:** A certificate of registration granted by the Mississippi Insurance Department to a private review agent, and is not transferable. Any valid and active certificate issued by the Mississippi Department of Health prior to July 1, 2024, shall be honored by the Mississippi Department of Insurance until such time as the expiration or revocation of said certificate.
- (6) **Certification:** A determination by a utilization review organization that an admission, extension of stay, or other medical service has been reviewed and based on the information provided, qualifies as medically necessary and appropriate under the medical review requirements of the applicable health benefit plan.
- (7) **Certification Number:** The number assigned to each certified private review agent. This number is not transferable.
- (8) **Certified Private Review Agent:** A private review agent who meets all the criteria for certification as set forth in these rules and regulations, has paid all current fees, and has been assigned a certification number.
- (9) **Chronic Condition.** A medical condition that is medically complex, life threatening, long-term, or substantially disabling, including, but not limited to, chemotherapy for the treatment of cancer. Treatment for a chronic condition may include a recurring health care service or maintenance medication.
- (10) **Commissioner.** The Commissioner of Insurance.
- (11) **Clinical review criteria:** The written screening procedures, decision abstracts, clinical protocols and practice guidelines used by a health insurance issuer to determine the necessity and appropriateness of health care services.

- (12) **Concurrent Review:** Utilization review conducted during a patient's hospital stay or course of treatment.
- (13) **Consulting Physician:** A Medical Doctor, Doctor of Osteopathy, Dentist, Psychologist, Podiatrist or Chiropractor who possess the degree of skill ordinarily possessed and used by members of his or her profession in good standing, and actively engaged in the same type of practice and relevant specialty. The medical and osteopathy specialist shall be certified by the Boards within the American Board of Medical Specialists or the American Board of Osteopathy.
- (14) **Department:** The Mississippi Insurance Department.
- (15) **Emergency medical condition:** A medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
 - a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
 - b. Serious impairment to bodily functions; or
 - c. Serious dysfunction of any bodily organ or part.
- (16) **Emergency services:** Health care items and services furnished or required to evaluate and treat an emergency medical condition.
- (17) **Enrollee:** The individual who has elected to contract for, or participate in, a health benefit plan for their self and/or their dependents.
- (18) **Expedited Appeal:** A request for additional review of a utilization review organization's determination not to certify an admission, extension of stay, or other medical service. An expedited appeal request may be called a reconsideration request by some utilization review organizations.
- (19) **Health care professional:** A physician, a registered professional nurse or other individual appropriately licensed or registered to provide health care services
- (20) **Health care provider:** Any physician, hospital, ambulatory surgery center, or other person or facility that is licensed or otherwise authorized to deliver health care services.
- (21) **Health care service.** Any services or level of services included in the

furnishing to an individual of medical care or the hospitalization incident to the furnishing of such care, as well as the furnishing to any person of any other services for the purpose of preventing, alleviating, curing, or healing human illness or injury, including behavioral health, mental health, home health and pharmaceutical services and products.

- (22) **Health insurance issuer:** Shall have the meaning given to that term in *Miss. Code Ann.* §83-9-6.3, and all private review agents and utilization review plans, as both terms are defined in *Miss. Code Ann.* §41-83-1, with the exception of employee or employer self-insured health benefit plans under the federal Employee Retirement Income Security Act of 1974 or health care provided pursuant to the Workers' Compensation Act.
- (23) **Hospital:** An institution which is primarily engaged in providing to inpatients and outpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons, or rehabilitation services for the rehabilitation of injured, disabled or sick persons, and also, means a place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment and illness, disease, injury or deformity, or a place devoted primarily to providing obstetrical or other medical, surgical or nursing care of individuals, whether or not any such place be organized or operated for profit and whether any such place be publicly or privately owned. The term "Hospital" does not include convalescent or boarding homes, children's homes, homes for the aged or other like establishments where room and board only are provided, nor does it include offices or clinics where patients are not regularly kept as bed patients. The term "Hospital" includes Rural Emergency Hospitals which are licensed as such through the Mississippi Department of Health.
- (24) **Medically Necessary:** A health care professional exercising prudent clinical judgment would provide care to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms and that are:
 - a. In accordance with generally accepted standards of medical practice; and
 - b. Clinically appropriate in terms of type, frequency, extent, site and duration and are considered effective for the patient's illness, injury or disease; and not primarily for the convenience of the patient, treating physician, other health care professional, caregiver, family member or other interested party, but focused on what is best for the patient's health outcome.

- (25) **Patient:** The intended recipient of the proposed health care, his/her representative, and/or the enrollee.
- (26) **Physician:** Any person with a valid doctor of medicine, doctor of osteopathy or doctor of podiatry degree.
- (27) **Physician Advisor:** A physician representing the claim administrator/utilization review organization who provides advice on whether to certify an admission, extension of stay, or other medical service as being medically necessary and appropriate.
- (28) **Private Review Agent:** A non-hospital affiliated person or entity performing utilization review on behalf of:
 - a. An employer or employees in the State of Mississippi; or
 - b. A third party that provides or administers hospital and medical benefits to citizens of this state, including: a health maintenance organization issued a certificate of authority under and by virtue of the laws of the State of Mississippi, or a health insurer, nonprofit health service plan, health insurance service organization, or preferred provider organization or other entity offering health insurance policies, contracts or benefits in this state.
- (29) **Prior authorization:** The process by which a health insurance issuer determines the medical necessity and medical appropriateness of an otherwise covered health care service before the rendering of such health care service. "Prior authorization" includes any health insurance issuer's requirement that an enrollee, health care professional or health care provider notify the health insurance issuer before, at the time of, or concurrent to providing a health care service.
- (30) **Provider Utilization Review Representative:** The person(s) in a physician's office or hospital designated by the physician or hospital to provide the necessary information to complete the review process.
- (31) **Review Criteria:** The written policies, decision rules, medical protocols, or guides used by the utilization review organization to determine certification [e.g., Appropriateness Evaluation Protocol (AEP) and Intensity of Service, Severity of Illness, Discharge, and Appropriateness Screens (ISD-A)].
- (32) **Urgent health care service:** A health care service with respect to which the application of the time periods for making a non-expedited prior authorization that in the opinion of a treating health care professional or

health care provider with knowledge of the enrollee's medical condition:

- a. Could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function;
- b. Could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review; or
- c. Could lead to likely onset of an emergency medical condition if the service is not rendered during the time period to render a prior authorization determination for an urgent medical service.

(33) **Urgent health care service:** For the purposes of this regulation, urgent health care service does not include emergency services.

(34) **Utilization Review:** A system for reviewing the appropriate and efficient allocation of hospital resources and medical services given or proposed to be given to a patient or group of patients. More specifically, utilization review refers to pre-service determination of the medical necessity or appropriateness of services to be rendered in a hospital setting either on an inpatient or outpatient basis, when such determination results in approval or denial of payment for the services. It includes both prospective and concurrent review and may include retrospective review under certain circumstances.

(35) **Utilization Review Plan:** A description of the utilization review procedures of a private review agent.

Source: *Miss. Code Ann.* §41-83-1, et seq. (Rev. 2023); *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.06 Application for Certification

(1) A private review agent who approves or denies payment or who recommends approval or denial of payment for hospital or medical services or whose review results in approval or denial of payment for hospital or medical services on a case by case basis, may not conduct utilization review in this state unless the Mississippi Department of Insurance has granted the private review agent a certificate. **Any valid and active certificate issued by the Mississippi Department of Health prior to July 1, 2024, shall be honored by the Mississippi Department of Insurance until such time as the expiration or revocation of said certificate.**

(2) The Mississippi Insurance Department shall issue a certificate to any applicant that has met all the requirements and all applicable regulations of the Department.

- (3) A certificate is not transferable. When there is a change of ownership of the Certified Organization, a new application will be required and a new number will be issued.
- (4) Any information required by the Department with respect to customers, patients or utilization review procedures of a private review agent shall be held in confidence and not disclosed to the public.
- (5) A Private Review Agent applying for a certificate shall submit the following documentation to the Department:
- a. A completed application, signed and verified by the applicant;
 - b. A fee of \$1,500.00, made payable to Mississippi Insurance Department, either by business check, money order, or by electronic means; and
 - c. A utilization review plan which shall include all of the following components used by the private review agent to approve or deny payment or recommend approval or denial of payment in advance for proposed or delivered inpatient or outpatient care or retrospectively approve or deny under certain circumstances:
 - 1) Elements of review for:
 - i) Preadmission
 - ii) Admission
 - iii) Preauthorization
 - iv) Second Surgical Opinion
 - 2) Discharge Planning
 - i) Concurrent Review
 - ii) Retrospective Review
 - iii) Readmission Review
 - 3) Procedures for review, including:
 - i) Any form used during the review process;
 - ii) Time frames that shall be met during the review; and
 - iii) A written protocol describing every aspect of the review process;

- iv) A description and examples of review criteria to be used for the review;
- v) The provisions, procedures, and time frames by which patients, physicians, and hospitals may seek reconsideration or appeal of adverse decisions by the private review agent, including:
 - (a) A written protocol describing the appeals procedure;
 - (b) Any form which shall be completed during the appeals procedure;
 - (c) Time frames that shall be met during the appeal procedure; and
 - (d) The names and qualifications of personnel making final appeal determinations;
 - (i) The number, type, and qualification or qualifications of the personnel either employed or under contract to perform the utilization review;
 - (ii) The policies and procedures to ensure that a representative of the private review agent is accessible to patients and providers five (5) days a week during normal business hours in this state, 9 A.M. to 5 P.M.; and that a free telephone number be provided with adequate lines available and staffed. The procedure for handling after-hours inquiries shall be specified.
 - (iii) The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;
 - (iv) A copy of the materials designed to inform applicable patients and providers of the requirements of the utilization review plan; and
 - (v) A list (names and addresses) of the third party payors for which the private review agent is performing utilization review in this state.
- vi) Compliance with statutory prior authorization requirements as set forth in *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Source: *Miss. Code Ann.* §41-83-1, et seq. (rev. 2023); *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.07. Renewal of Certification.

- (1) A certificate expires on the second anniversary of its effective date unless certification has been renewed for a two (2) year term.

(2) Before the certification expires, the certified private review agent may renew its certification for an additional two (2) year term, if the certified private review agent:

- a. Is otherwise entitled to be certified;
- b. Pays to the Department the renewal fee of \$1,500.00, either by business check, money order, or by electronic means; and
- c. Submits to the Department:
 - i. A renewal application on the form that the Commissioner requires;
 - ii. An update of information as required under Rule 19.06;
 - iii. An annual report.

(3) The Department shall renew the certification of each certified private review agent, if the requirements of these regulations are met.

Source: *Miss. Code Ann.* §41-83-7 (Rev. 2023); *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.08 Denial or Revocation of Certification and Penalty

(1) The Commissioner shall deny a certificate to an applicant if the Department finds that the applicant does not:

- a. Have available the services of a sufficient number of registered nurses, that are supervised by appropriate physicians to efficiently carry out its utilization review activities;
 - i. Meet any applicable provisions of these rules and regulations relating to the qualifications of private review agents or the performance of utilization review the Department adopts relating to the qualifications of private review agents or the performance of utilization review;
 - ii. Have policies and procedures which protect the confidentiality of medical records in accordance with applicable state and federal laws; ~~or~~
 - iii. Make itself accessible to patients and providers five (5) working days a week during normal business hours in this state, or
 - iv. Does not comply with prior authorization standards as provided in *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

- (2) The Commissioner may revoke the certification of a private review agent if the Department finds that the agent:
- a. Does not comply with performance assurances;
 - b. Violates any provision of these rules and regulations;
 - c. Fails to substantially meet the standards and qualifications adopted by the Commissioner;
 - d. Does not comply with prior authorization standards as provided in *Miss. Code Ann.* §§ 83-5-901 through 83-5-937; or
 - e. Fails to comply with the regulations adopted by the Department.
- (3) Before denying or revoking a certificate, the Commissioner shall comply with the process for Administrative Hearings as provided in 19 Miss. Admin. Code, Part 1, Rule 15.08 and Rule 15.09, “Rules of Practice and Procedure before the Mississippi Insurance Department and State Fire Marshal’s Office”.
- (4) A private review agent may not disclose or publish individual medical records or any other confidential medical information obtained in the performance of utilization review activities without the patient's authorization or an order of a county, circuit or chancery court of Mississippi or a U. S. District Court. It is provided, however, that nothing in these regulations shall prohibit private review agents from providing information to the third party with whom the private review agent is under contract or acting on behalf of.

Source: *Miss. Code Ann.* §41-83-1, et. seq. (Rev. 2023);-*Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.09. Utilization Review Standards

(1) Responsibility for Obtaining Certification

- a. In the absence of any contractual agreement to the contrary, the enrollee is responsible for notifying the private review agent in a timely manner and obtaining certification for health care services, if required by the health benefit plan. A private review agent shall allow any licensed health care provider, or responsible patient representative, including a family member, to assist in fulfilling that responsibility.
- b. To ensure confidentiality, a private review agent must, when contacting a health care provider’s office or facility, or hospital, provide its certification number, the caller's name, and professional qualification to the designated utilization review representative in the health care provider’s office or facility, or hospital.

(2) Information Upon Which Utilization Review is Conducted

- a. When conducting routine prospective and concurrent utilization review, the private review agent shall collect only the information necessary to certify the admission, procedure or treatment and length of stay.
- b. A private review agent should not routinely expect hospitals and physicians to supply numerically codified diagnoses or procedures. The private review agent may ask for such coding, since if it is known, its inclusion in the data collected increases the effectiveness of the communication.
- c. The private review agent shall not routinely request copies of medical records on all patients reviewed. During prospective and concurrent review, copies of medical records should only be required when a difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay. In those cases, only the necessary or pertinent sections of the record should be required.
- d. Private review agents may request copies of medical records retrospectively for a number of purposes, including auditing the services provided, quality assurance, and evaluation of compliance with the terms of the health benefit plan or Utilization Review provisions. With the exception of the reviewing of records associated with an appeal or with an investigation of data discrepancies and unless otherwise provided for by contract or law, health care providers should be reimbursed the reasonable direct costs of duplicating requested records for retrospective review.
- e. Private review agents must comply with prior authorization standards as established by *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

(3) Except as otherwise provided in these standards, a private review agent should limit its initial data requirements to the following elements:

- a. Patient Information
 - i. Name
 - ii. Address
 - iii. Date of Birth
 - iv. Sex
 - v. Social Security Number or Patient ID Number

- vi. Name of Carrier or Plan
- vii. Plan ID Number
- b. Enrollee Information
 - i. Name
 - ii. Address
 - iii. Social Security Number or Employee ID Number
 - iv. Relation to Patient
 - v. Employer
 - vi. Health Benefit Plan
 - vii. Group Number/Plan ID Number
 - viii. Other Coverage Available (Workers' Comp., Medicare, etc.)
- c. Attending Physician/Practitioner Information
 - i. Name
 - ii. Address
 - iii. Phone Number
 - iv. Degree
 - v. Specialty/Certification Status
 - vi. Tax ID or Other ID Number
- d. Diagnosis/Treatment Information
 - i. Primary Diagnosis
 - ii. Secondary Diagnosis
 - iii. Proposed Procedure(s) or Treatment(s)
 - iv. Surgical Assistant Requirement
 - v. Anesthesia Requirement

- vi. Proposed Admission or Service Date(s)
 - vii. Proposed Procedure Date
 - viii. Proposed Length of Stay
- e. Clinical Information. Sufficient information for support of appropriateness and level of service proposed
- f. Facility Information
 - i. Type (such as in-patient, out-patient, rehab, etc.)
 - ii. Status (DRG exempt status, as needed)
 - iii. Name
 - iv. Address
 - v. Phone Number
 - vi. Tax ID or Other ID Number
- g. Concurrent (Continued Stay) Review Information
 - i. Clinical Contact Person
 - ii. Additional Days/Services Proposed
 - iii. Reasons for Extension
 - iv. Diagnosis (same/changed)
 - v. Clinical Information (Sufficient to support, as above)
- h. Admissions to Facilities Other Than Acute Medical/Surgical Hospitals
 - i. History of Present Illness
 - ii. Patient Treatment Plan and Goals
 - iii. Prognosis
 - iv. Staff Qualifications
 - v. 24 Hour Availability of Staff
- i. Compliance with prior authorization standards as established by *Miss. Code Ann.* §§

83-5-901 through 83-5-937.

(4) Special Situations

- a. Additional information may be required for other specific review functions such as discharge planning or catastrophic case management. Second opinion information may also be required, when applicable, sufficient to support benefit plan requirements.
- b. Information in addition to that described in this section may be requested by the private review agent or voluntarily submitted by the provider, when there is significant lack of agreement between the private review agent and health care provider regarding the appropriateness of certification during the review or appeal process. "Significant lack of agreement" means that the private review agent has:
 - i. Tentatively determined, through its professional staff, that a service cannot be certified;
 - ii. Referred the case to a physician for review; and
 - iii. Talked to or attempted to talk to the attending physician for further information.
- c. A private review agent should share all clinical and demographic information on individual patients among its various divisions (e.g., certification, discharge planning, case management) to avoid duplicate requests for information from enrollee or providers.

(5) Procedures For Review Determination

- a. Each private review agent shall have written procedures to ensure that reviews are conducted in a timely manner and as expeditiously as the enrollee's condition requires.
- b. Each private review agent shall make utilization reviews of prior authorization after obtaining all necessary information within pursuant to the timeframes establish in Rule 19.09(6) for nonurgent circumstances and Rule 19.09(7) for urgent circumstances, unless a longer minimum time frame is required under federal law for the health insurance issuer and the health care service at issue. Collection of the necessary information may necessitate a discussion with the attending physician or, based on the requirements of the health benefit plan, may involve a completed second opinion review.
- c. A private review agent may review ongoing inpatient stays, but shall not routinely conduct daily review on all such stays. The frequency of the review for extension

of the initial determination should vary based on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity. Routine concurrent review generally should not be necessary earlier than 24 hours prior to the lapse of the certified length of stay.

- d. Each private review agent shall have in place written procedures for providing notification of its determination regarding certification, recertification, or extensions of previously authorized length of stay in accordance with the following:
 - i. When an initial determination is made to certify, notification shall be provided promptly either by telephone or in writing, via letter or electronic mail, to the attending physician. The notification shall be transmitted in writing to the hospital and attending physician, as well as to the enrollee or patient, within two working days.
 - ii. A determination to certify resulting from concurrent review shall be transmitted to the attending physician by telephone or in writing within one working day of receipt of all information necessary to complete the review process or prior to the end of the current certified period.
 - iii. If a private review agent transmits written confirmation of certification for continued hospitalization, that notification shall include the number of extended days, the new total number of days approved, and the date of admission.
 - iv. When a determination is made not to certify a hospital or surgery facility admission or extension of a hospital stay or other service requiring review determination, the attending physician shall be notified by telephone within one working day and a written notification should be sent within one working day to the hospital, attending physician and the enrollee or patient. The written notification shall include the principal reason(s) for the determination and the way to initiate an appeal of the determination if the enrollee, patient, or their representative so chooses. Reasons for a determination not to certify shall include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the attending physician.
- (6) Utilization review of prior authorizations in nonurgent circumstances. If a health insurance issuer requires prior authorization of a health care service, the health insurance issuer must make an approval or adverse determination and notify the enrollee, the enrollee's health care professional, and the enrollee's health care provider of the approval or adverse determination as expeditiously as the enrollee's condition requires but no later

than seven (7) calendar days after obtaining all necessary information to make the approval or adverse determination, unless a longer minimum time frame is required under federal law for the health insurance issuer and the health care service at issue. As used in this section, "necessary information" includes the results of any face-to-face clinical evaluation, second opinion or other clinical information that is directly applicable to the requested service that may be required. Notwithstanding the foregoing provisions of this section, health insurance issuers must comply with the requirements of *Miss. Code Ann.* § 83-9-6.3 to respond by two (2) business days for prior authorization requests for pharmaceutical services and products.

(7) Utilization review of prior authorizations in urgent circumstances.

- a. If requested by a treating health care provider or health care professional for an enrollee, a health insurance issuer must render an approval or adverse determination concerning urgent health care services and notify the enrollee, the enrollee's health care professional and the enrollee's health care provider of that approval or adverse determination as expeditiously as the enrollee's condition requires but no later than forty-eight (48) hours after receiving all information needed to complete the review of the requested health care services, unless a longer minimum time frame is required under federal law for the health insurance issuer and the urgent health care service at issue.
- b. To facilitate the rendering of a prior authorization determination in conformance with this section, a health insurance issuer must establish a mechanism to ensure health care professionals have access to appropriately trained and licensed clinical personnel who have access to physicians for consultation, designated by the plan to make such determinations for prior authorization concerning urgent care services.

(8) Notwithstanding language to the contrary elsewhere contained herein, if a licensed physician certifies in writing to an insurer within seventy-two (72) hours of an admission that the insured person admitted was in need of immediate hospital care for emergency services, such shall constitute a prima facie case of the medical necessity of the admission. To overcome this, the entity requesting the utilization review and/or the private review agent must show by clear and convincing evidence that the admitted person was not in need of immediate hospital care.

(9) Private review agents shall have in place written procedures to address the failure of a health care provider, patient, or their representative to provide the necessary information for review. If the patient or provider will not release the necessary information to the Utilization Review Organization, the Utilization Review Organization may deny certification in accordance with its own policy or that of the health benefit plan.

Source: *Miss. Code Ann.* §41-83-1, et. seq. (Rev. 2023); *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.10. Appeals of Determinations Not to Certify

- (1) Each private review agent shall have in place procedures for appeals of determinations not to certify an admission, procedure, service or extension of stay. The right to appeal shall be available to the patient or enrollee, and to the attending physician on behalf of the patient. The procedures for appeals shall include, at a minimum, the following statement:
 - a. Any person aggrieved by a final decision of the department or a private review agent in a contested case under this act shall have the right of judicial appeal to the chancery court of the county of the residence of the aggrieved person.
 - b. Notwithstanding any provision of this act, the insured shall have the express right to pursue any legal remedies he may have in a court of competent jurisdiction.
- (2) If a prior review agent has clear and convincing evidence that a health care professional or health care provider has knowingly and willingly submitted false or fraudulent requests for prior authorization to the health insurance issuer, the issuer shall notify and provide ~~that~~ the information in the manner as provided in Subsection (3) of this Section to the Commissioner of Insurance.
- (3) If a health insurance issuer intends either to implement a new prior authorization requirement or restriction or amend an existing requirement or restriction, the health insurance issuer shall provide contracted health care professionals and contracted health care providers of enrollees written notice of the new or amended requirement or amendment no less than sixty (60) days before the requirement or restriction is implemented. Written notice may take the form of a conspicuous notice posted on the health insurance issuer's public website or portal for contracted health care professionals and contracted health care providers. A health insurance issuer shall provide email notices to health care professionals or health care providers if the health care professional or health care provider has requested to receive the notice through email. The health insurance issuer shall ensure that the new or amended requirement is not implemented unless the health insurance issuer's website has been updated to reflect the new or amended requirement or restriction. Written notice of a new, amended, or restricted prior authorization requirement, as required by *Miss. Code Ann.* §83-5-909(6), may be provided less than sixty (60) days in advance if a health insurance issuer determines and contemporaneously notifies the department in writing and submitted to priorauthoriztion.notice@mid.ms.gov :
 - (a) The health insurance issuer has identified fraudulent or abusive practices related to the health care service;
 - (b) The health care service is unavailable or scarce which necessitates the use of an alternative health care service;
 - (c) The health care service is newly introduced to the health care market and a delay in providing coverage for the health care service and would not be in the best interests of enrollees;

(d) The health care service is the subject of a clinical trial authorized by the United States Food and Drug Administration; or

(e) Changes to the health care service or its availability are otherwise required by law to be made by the health insurance issuer in less than sixty (60) days.

Source: *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.11. Computation of Time

(1) Utilization review of prior authorizations in nonurgent circumstances. If a health insurance issuer requires prior authorization of a health care service, the health insurance issuer must make an approval or adverse determination and notify the enrollee, the enrollee's health care professional, and the enrollee's health care provider of the approval or adverse determination as expeditiously as the enrollee's condition requires but no later than seven (7) calendar days after obtaining all necessary information to make the approval or adverse determination, unless a longer minimum time frame is required under federal law for the health insurance issuer and the health care service at issue. As used in this section, "necessary information" includes the results of any face-to-face clinical evaluation, second opinion or other clinical information that is directly applicable to the requested service that may be required. Notwithstanding the foregoing provisions of this section, health insurance issuers must comply with the requirements of *Miss. Code Ann.* § 83-9-6.3 to respond by two (2) business days for prior authorization requests for pharmaceutical services and products.

(2) Utilization review of prior authorizations in urgent circumstances.

- a. If requested by a treating health care provider or health care professional for an enrollee, a health insurance issuer must render an approval or adverse determination concerning urgent health care services and notify the enrollee, the enrollee's health care professional and the enrollee's health care provider of that approval or adverse determination as expeditiously as the enrollee's condition requires but no later than forty-eight (48) hours after receiving all information needed to complete the review of the requested health care services, unless a longer minimum time frame is required under federal law for the health insurance issuer and the urgent health care service at issue.
- b. To facilitate the rendering of a prior authorization determination in conformance with this section, a health insurance issuer must establish a mechanism to ensure health care professionals have access to appropriately trained and licensed clinical personnel who have access to physicians for consultation, designated by the plan to make such determinations for prior authorization concerning urgent care services.

(3) Notwithstanding language to the contrary elsewhere contained herein, if a licensed physician certifies in writing to an insurer within seventy-two (72) hours of an admission

that the insured person admitted was in need of immediate hospital care for emergency services, such shall constitute a prima facie case of the medical necessity of the admission. To overcome this, the entity requesting the utilization review and/or the private review agent must show by clear and convincing evidence that the admitted person was not in need of immediate hospital care.

- (4) Notwithstanding the foregoing provisions of this Rule, health insurance issuers must comply with the requirements of *Miss. Code Ann.* § 83-9-6.2 to respond by two (2) business days for prior authorization requests for pharmaceutical services and products.

Source: *Miss. Code Ann.* §§41-83-1, et. seq; §83-9-6.2; *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.12. Urgent Prior Authorization Requests; Access to Physicians.

To facilitate an Urgent Prior Authorization request in a timely manner as required by statute and this Rule, a health insurance issuer must establish a policy to ensure Health Care Professionals, defined as a physician, registered professional nurse or other individual appropriately licensed or registered to provide health care services, have access to appropriately trained and licensed clinical personnel who have access to physicians for consultation, designated by the plan to make such determinations for prior authorization concerning urgent care services. This policy must include the following:

- (1) Identification of the physicians available for consultation for each designated health service that requires prior authorization and contact information for those physicians.
- (2) Time frame for physicians to respond to Health Care Professionals or other clinical personnel.
- (3) Identification of the trained and licensed clinical personnel available for consultation for each designated health service that requires prior authorization and a method to contact said licensed clinical personnel. Identification may be made by providing the job title of the licensed clinical personnel.
- (4) The expertise required by the consulting physicians, which should take into consideration the physician's specialty and experience as determined by the health care services requiring Urgent Prior Authorization.

This policy is separate from the requirement of use of physicians qualified to review appeals. Such policy shall be submitted to the Department upon request.

Source: *Miss. Code Ann.* §41-83-1, et. seq-*Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.13. Notification for Adverse Determinations / Form

When a provider or facility makes a request for prior authorization, should a health insurance issuer make an adverse determination, the health insurance issuer shall include in writing the

following in the notification to the enrollee, the enrollee's health care professional, and the enrollee's health care provider:

- (1) The reasons for the adverse determination and related evidence-based criteria, including a description of any missing or insufficient documentation;
- (2) The right to appeal the adverse determination;
- (3) Instructions on how to file the appeal; and
- (4) Additional documentation necessary to support the appeal.

A decision may be provided orally, but subsequent written notice must also be provided within twenty-four (24) hours of the oral decision. A denial must include the department and credentials of the individual who has the authorizing authority to approve or deny the request, including a phone number to contact the authorizing authority and a notice regarding the enrollee's appeal rights and process.

A health insurance issuer, when sending a notice to a covered person of a denial of a request for prior authorization made under this section, shall include with such notice the following statement in bold and in twelve (12) point font:

**THE STATEMENT BELOW IS REQUIRED BY MISSISSIPPI INSURANCE
DEPARTMENT REGULATION**

ACTIONS YOU CAN TAKE AND HOW TO GET HELP

You, or someone on your behalf, recently requested approval from your health insurance plan for a health care service or item. Your health insurance plan denied the request.

You have the right to ask your health insurance plan to change this decision. This is called an internal appeal. If the request is not approved after an internal appeal, your request may be eligible for a review by an independent third party. This is called an external review. The independent third party may change your health insurance plan's decision, or it may confirm your health insurance plan's decision.

Please read carefully the information your health insurance plan has provided with this insert. This information explains the reason(s) for the health insurance plan's decision, as well as how to ask for an internal appeal or external review, including any deadlines and timing.

You should also feel free to contact your health insurance plan or the Mississippi Insurance Department to help you understand your rights and answer any questions. Contact information for both your health insurance plan and the Department is included in the information your health insurance plan has provided.

Source: *Miss. Code Ann.* §41-83-1, et. seq.; *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.14. Qualifications of persons reviewing appeals

- 1) A health insurance issuer must ensure that all appeals are reviewed by a physician when the request is by a physician or a representative of a physician. The physician must:
 - a. Possess a current and valid nonrestricted license to practice medicine in any United States jurisdiction;
 - b. Be certified by the board(s) of the American Board of Medical Specialists or the American Board of Osteopathy within the relevant specialty of a physician who typically manages the medical condition or disease;
 - c. Be knowledgeable of, and have experience providing, the health care services under appeal;
 - d. Not have been directly involved in making the adverse determination; and
 - e. Consider all known clinical aspects of the health care service under review, including, but not limited to, a review of all pertinent medical records provided to the health insurance issuer by the enrollee's health care professional or health care provider and any medical literature provided to the health insurance issuer by the health care professional or health care provider.

Source: *Miss. Code Ann.* §41-83-1, et. seq.; *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.15. Change of patient status to emergency status after submission of prior authorization request.

Notwithstanding language to the contrary elsewhere contained herein, if a licensed physician certifies in writing to an insurer within seventy-two (72) hours of an admission that the insured person admitted was in need of immediate hospital care for emergency services, such shall constitute a prima facie case of the medical necessity of the admission. To overcome this, the entity requesting the utilization review and/or the private review agent must show by clear and convincing evidence that the admitted person was not in need of immediate hospital care.

Source: *Miss. Code Ann.* §41-83-21 (Rev. 2023); *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.16. Length of Approvals.

(1) A prior authorization approval shall be valid for the lesser of six (6) months after the date the health care professional or provider receives the prior authorization approval or the length of treatment as determined by the patient's health care professional or the renewal of the policy or plan, and the approval period shall be effective regardless of any changes, including any changes in dosage for a prescription drug prescribed by the health care professional. Notwithstanding the foregoing, a health insurer and an enrollee or his/her health care professional may extend a prior authorization approval for a longer period by agreement. All dosage increases must be based on established evidentiary standards, and nothing in this section shall prohibit a health insurance

issuer from having safety edits in place. This provision shall not apply to the prescription of benzodiazepines or Schedule II narcotic drugs, such as opioids.

(2) Nothing in this provision shall require a policy or plan to cover any care, treatment, or services for any health condition that the terms of coverage otherwise completely exclude from the policy's or plan's covered benefits without regard for whether the care, treatment or services are medically necessary.

Source: *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.17. Approvals for chronic conditions.

(1) If a health insurance issuer requires a prior authorization for a recurring health care service or maintenance medication for the treatment of a chronic or long-term condition, including, but not limited to, chemotherapy for the treatment of cancer, the approval shall remain valid for the lesser of twelve (12) months from the date the health care professional or health care provider receives the prior authorization approval or the length of the treatment as determined by the patient's health care professional. Notwithstanding the foregoing, a health insurer and an enrollee or his or her health care professional may extend a prior authorization approval for a longer period, by agreement. This section shall not apply to the prescription of benzodiazepines or Schedule II narcotic drugs, such as opioids.

(2) Nothing in this section shall require a policy or plan to cover any care, treatment or services for any health condition that the terms of coverage otherwise completely exclude from the policy's or plan's covered benefits without regard for whether the care, treatment, or services are medically necessary.

Source: *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.18. Continuity of Prior Approvals.

(1) On receipt of information documenting a prior authorization approval from the enrollee or from the enrollee's health care professional or health care provider, a health insurance issuer shall honor a prior authorization granted to an enrollee from a previous health insurance issuer for at least the initial ninety (90) days of an enrollee's coverage under a new health plan, subject to the terms of the member's coverage agreement.

(2) During the time period described in subsection (1) of this rule, a health insurance issuer may perform its own review to grant a prior authorization approval subject to the terms of the member's coverage agreement.

(3) If there is a change in coverage or approval criteria for a previously authorized health care service, the change in coverage or approval criteria does not affect an enrollee who received prior authorization approval before the effective date of the change for the remainder of the enrollee's plan year.

(4) Except to the extent required by medical exceptions processes for prescription drugs, nothing in this rule shall require a policy or plan to cover any care, treatment or services for any health condition that the terms of coverage otherwise completely exclude from the policy's or plan's

covered benefits without regard for whether the care, treatment or services are medically necessary.

Source: *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.19. Revocations of prior authorizations.

(1) A health insurance issuer may not revoke or further limit, condition or restrict a previously issued prior authorization approval while it remains valid under this act.

(2) Notwithstanding any other provision of law, if a claim is properly coded and submitted timely to a health insurance issuer, the health insurance issuer shall make payment according to the terms of coverage on claims for health care services for which prior authorization was required and approval received before the rendering of health care services, unless one (1) of the following occurs:

(a) It is timely determined that the enrollee's health care professional or health care provider knowingly and without exercising prudent clinical judgment provided health care services that required prior authorization from the health insurance issuer or its contracted private review agent without first obtaining prior authorization for those health care services;

(b) It is timely determined that the health care services claimed were not performed;

(c) It is timely determined that the health care services rendered were contrary to the instructions of the health insurance issuer or its contracted private review agent or delegated reviewer if contact was made between those parties before the service being rendered;

(d) It is timely determined that the enrollee receiving such health care services was not an enrollee of the health care plan; or

(e) The approval was based upon a material misrepresentation by the enrollee, health care professional, or health care provider; as used in this paragraph, "material" means a fact or situation that is not merely technical in nature and results or could result in a substantial change in the situation.

(3) Nothing in this section shall preclude a private review agent or a health insurance issuer from performing post-service reviews of health care claims for purposes of payment integrity or for the prevention of fraud, waste, or abuse.

Source: *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.20 Standardized electronic prior authorizations.

(1) By January 1, 2025, all health insurance issuer or designee utilization review organization shall make available a standardized electronic prior authorization request transaction process using an internet webpage, internet webpage portal, or similar electronic, internet, and web-based system.

(2) Not later than January 1, 2027, all health care professionals and health care providers shall be required to use the standardized electronic prior authorization request transaction process made available as required by subsection (1) of Rule 19.20.

(3) Not later than January 1, 2027, all health insurance issuers or designee utilization review organization shall comply with the Centers for Medicare & Medicaid Services, *CMS-0057-F, Prior Authorization and Interoperability Final Rule* (2024), regarding automation of prior authorization application programming interfaces.

Source: *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.21. Reports to the Department

(1) By June 1, 2025, and each June 1 after that date, a health insurance issuer shall report to the department, on a form issued by the department, the following aggregated trend data, de-identified of protected health information, related to the insurer's practices and experience for the prior plan year for health care services submitted for payment:

- (a) The number of prior authorization requests;
- (b) The number of prior authorization requests denied;
- (c) The number of prior authorization appeals received;
- (d) The number of adverse determinations reversed on appeal;
- (e) Of the total number of prior authorization requests, the number of prior authorization requests that were not submitted electronically;
- (f) The ten (10) health care services that were most frequently denied through prior authorization;
- (g) The ten (10) reasons prior authorization requests were most frequently denied;
- (h) The number of claims for health care services that were examined through a post-service utilization review process;
- (i) The number and percentage of claims for health care services denied through post-service utilization review; and
- (j) The ten (10) health care services that were most frequently denied as a result of post-service utilization reviews.
- (k) Any prior authorization requirements that have been removed.

(2) All reports required by this section shall be considered public records under the Mississippi Public Records Act of 1983 and the Department shall make all reports freely available to requestors and post all reports to its public website without redactions.

Source: *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.22. Prior Authorization Statistics

Pursuant to *Miss. Code Ann.* §83-5-909(7), health insurance issuers using prior authorization shall make statistics available regarding prior authorization approvals and denials on their website in a readily accessible format. Following each calendar year, the statistics must be updated annually, by March 31, and include all of the following information:

- (1) A list of all health care services, including medications, that are subject to prior authorization;
- (2) The percentage of standard prior authorization requests that were approved, aggregated for all items and services;
- (3) The percentage of standard prior authorization requests that were denied, aggregated for all items and services;
- (4) The percentage of prior authorization requests that were approved after appeal, aggregated for all items and services;
- (5) The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services;
- (6) The percentage of expedited prior authorization requests that were approved, aggregated for all items and services;
- (7) The percentage of expedited prior authorization requests that were denied, aggregated for all items and services;
- (8) The average and median time that elapsed between the submission of a request and a determination by the payer, plan or health insurance issuer, for standard prior authorization, aggregated for all items and services;
- (9) The average and median time that elapsed between the submission of a request and a decision by the payer, plan or health insurance issuer, for expedited prior authorizations, aggregated for all items and services

Source: *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.23. Enforcement and administration

The Department may issue a cease-and-desist order or require a private review agent or health insurance issuer to submit a plan of correction for violation of *Miss. Code Ann.* §§ 83-5-901 through 83-5-937. The Department may impose upon a private review agent, health benefit plan or health insurance issuer an administrative fine not to exceed Ten Thousand Dollars (\$10,000.00) per violation for failure to submit a requested plan of correction, failure to comply with its plan of correction, or repeated violations of this act. All hearings related to the enforcement and administration of this act shall be in accordance with 19 Miss. Admin. Code Part 1, Ch. 15, as may be amended from time to time. All fines collected by the Department under this section shall be deposited into the State General Fund.

Upon receipt of a complaint by any person or his or her treating physician who has evidence that his or her health insurance issuer or health benefit plan is in violation of the provisions contained in *Miss. Code Ann.* §§ 83-5-901 through 83-5-937, these regulations, the Department shall review all complaints received and investigate all complaints that it deems a potential violation in accordance with normal Department policies and procedures and in a fair, efficient and timely manner

Source: *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19.24. Penalties

(1) A failure by a health insurance issuer to comply with the deadlines and other requirements specified in this act shall result in any health care services subject to review to be automatically deemed authorized by the health insurance issuer or its contracted private review agent.

(2) A private review agent, health benefit plan or health insurance issuer. The failure of a private review agent, health benefit plan or health insurance issuer to comply with the provisions of *Miss. Code Ann.* §§ 83-5-901 through 83-5-937 or the provisions of this Regulation shall subject said entity to the penalty provisions as provided in *Miss. Code Ann.* § 83-5-933.

Source: *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.

Rule 19. 25. Severability

If any provision of this Regulation, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Regulation, and the application of 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. 2022).

Rule 19.26. Effective Date

This Regulation shall be effective on and after January 1, 2025.

Source: *Miss. Code Ann.* § 25-43-3.108 (Rev. 2022); *Miss. Code Ann.* §§ 83-5-901 through 83-5-937.