participant shall properly complete the appropriate form that the Retirement Agency provides and file it with the Retirement Agency.

(2) A form to request a rollover is properly completed if it is completed, dated, and signed in accordance with the form's instructions.

R. DEAN KENDERINE
Executive Director
Maryland State Retirement and Pension System

Title 31
MARYLAND INSURANCE ADMINISTRATION

Subtitle 10 HEALTH INSURANCE — GENERAL

31.10.06 Standards for Medicare Supplement Policies

Authority: Health-General Article, §§19-705 and 19-706; Insurance Article, §§2-109 and 8-403(b), Title 15, Subtitle 9, and Title 27; Annotated Code of Maryland

Notice of Proposed Action

[18-310-P]

The Insurance Commissioner proposes to amend Regulations **.02, .28,** and **.30** and adopt new Regulation **.31** under **COMAR 31.10.06 Standards for Medicare Supplement Policies**.

Statement of Purpose

The purpose of this action is to conform COMAR to the NAIC Medicare Supplement Model, which was changed due to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Comparison to Federal Standards

There is a corresponding federal standard to this proposed action, but the proposed action is not more restrictive or stringent.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Tyler Hoblitzell, Legislative and Regulatory Analyst, Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202, or call 410-468-2488, or email to insuranceregreview.mia@maryland.gov, or fax to 410-468-2020. Comments will be accepted through December 10, 2018. A public hearing has not been scheduled.

.02 Definitions.

A. (text unchanged)

B. Terms Defined.

(1)—(20) (text unchanged)

(21)"Newly eligible for Medicare" means the individual:

(a) Attained age 65; or

(b) Became entitled to benefits under part A pursuant to §226(b) or 226A of the Social Security Act, or is deemed to be eligible for benefits under §226(a) of the Social Security Act.

[(21)] *(22)*—[(26)] *(27)* (text unchanged)

.28 Standard Medicare Supplement Benefit Plans for 2010 Plans.

A.—G. (text unchanged)

H. Make-up of 2010 Standardized Benefit Plans.

(1)—(6) (text unchanged)

(7) *Standardized Medicare Supplement Benefit Plan G.*

(a) Standardized Medicare supplement benefit Plan G shall include only the following: The core benefits as defined in Regulation .27C of this chapter, plus 100 percent of the Medicare Part A Deductible, Skilled Nursing Facility Care, 100 percent of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in Regulation .27D(1), (3), (5), and (6) of this chapter.

(b) Effective January 1, 2020, the standardized benefit plan described in Regulation .31B(3) of this chapter (Re-designated Plan G High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

(8)—(11) (text unchanged)

I. (text unchanged)

.30 Outlines of Coverage for [2010] Standardized Medicare Supplement Benefit Plans.

A. Forms.

(1) The issuer shall include in the outline of coverage for:

(a) [2010 plan policies] *Policies* or certificates *sold with an effective date for coverage on or after June 1, 2010 and before January 1, 2020,* the forms that appear in §§B*(1), C—G, H(1), and I*—L of this regulation, in the order that the forms appear in this regulation*; and*

(b) Policies and certificates with an effective date for coverage on or after January 1, 2020, the forms that appear in §§B(2), C—G, H(2), and I—L of this regulation, in the order that the forms appear in this regulation.

(2) (text unchanged)

B. Cover Page.

(1) Benefit Chart of Medicare Supplement Plans Sold With an Effective Date for Coverage on or After June 1, 2010 *and Before January 1, 2020.*

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

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

Basic Benefits:

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

(existing table unchanged)

* 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 ${insert amount of Plan F high deductible} deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed ${insert amount of Plan F high deductible}. 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

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

[DISCLOSURES

Use this outline to compare benefits and premiums among policies.

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

READ YOUR POLICY VERY CAREFULLY

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

If you find that you are not satisfied with your policy, you may return it to {insert insurer'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

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

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 Regulation .28G of this chapter.}

{Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Commissioner.}

(2) Benefit Chart of Medicare Supplement Plans Sold on or After January 1, 2020.

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✔means 100% of the benefit is paid.

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

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of {Insert amount of Plans F and G high deductible} before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible Plan G does not cover the Medicare Part B deductible. However, high deductible Plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

PREMIUM INFORMATION

We {insert insurer'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

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

If you find that you are not satisfied with your policy, you may return it to {insert insurer'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

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

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

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 Regulation .28G of this chapter.}

{Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Commissioner.}

C.—F. (text unchanged)

G. Plan F or High Deductible Plan F.

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] *you have* paid a calendar year ${Insert amount of Plan F high deductible} deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are ${Insert amount of Plan F high deductible}. 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 ${Insert amount of Plan F high deductible} DEDUCTIBLE,**} PLAN PAYS	{IN ADDITION TO ${Insert amount of Plan F high deductible} DEDUCTIBLE,**} YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ${Insert amount of Medicare Part A deductible}	${Insert amount of Medicare Part A deductible} (Part A Deductible)	$0
61st thru 90th day	All but ${Insert amount equal to 25% of Medicare Part A deductible} a day	${Insert amount equal to 25% of Medicare Part A deductible} a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but ${Insert amount equal to 50% of Medicare Part A deductible} a day	${Insert amount equal to 50% of Medicare Part A deductible} 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 ${Insert amount equal to 12.5% of Medicare Part A deductible} a day	Up to ${Insert amount equal to 12.5% of Medicare Part A deductible} a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints [Additional amounts]	$0 [100%]	3 pints [$0]	$0 [$0]
Additional amounts	*100%*	*$0*	*$0*
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

***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 ${Insert amount of Medicare Part B deductible} of Medicare-approved amounts for the 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] *you have* paid a calendar year ${Insert amount of Plan F high deductible} deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are ${Insert amount of Plan F high deductible}. 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 ${Insert amount of Plan F high deductible} DEDUCTIBLE,**} PLAN PAYS	{IN ADDITION TO ${Insert amount of Plan F high deductible} 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. – CLINICAL LABORATORY SERVICES-TESTS FOR DIAGNOSTIC SERVICES (text unchanged)			
PARTS A & B			
SERVICES	MEDICARE PAYS	{AFTER YOU PAY ${Insert amount of Plan F high deductible} DEDUCTIBLE,**} PLAN PAYS	{IN ADDITION TO ${Insert amount of Plan F high deductible} DEDUCTIBLE,**} YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES – Remainder of Medicare-approved amounts (text unchanged)			
OTHER BENEFITS-NOT COVERED BY MEDICARE			
SERVICES	MEDICARE PAYS	{AFTER YOU PAY ${Insert amount of Plan F high deductible} DEDUCTIBLE,**} PLAN PAYS	{IN ADDITION TO ${Insert amount of Plan F high deductible} DEDUCTIBLE,**} YOU PAY
FOREIGN TRAVEL-NOT COVERED BY MEDICARE – Remainder of Charges (text unchanged)			

H. Plan G *and Plan G or High Deductible Plan G.*

(1) Plan G.(text unchanged)

(2) Plan G or High Deductible Plan G.

PLAN G *or HIGH DEDUCTIBLE PLAN G*

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

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

*{**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year ${Insert amount of Plan G high deductible} deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are ${Insert amount of Plan G high*

deductible}. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.}

SERVICES	MEDICARE PAYS	*{AFTER YOU PAY ${Insert amount of Plan G high deductible} DEDUCTIBLE,**}* PLAN PAYS	*{IN ADDITION TO ${Insert amount of Plan G high deductible} DEDUCTIBLE,**}* YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but ${Insert amount of Medicare Part A deductible}	${Insert amount of Medicare Part A deductible} (Part A Deductible)	$0
61st thru 90th day	All but ${Insert amount equal to 25% of Medicare Part A deductible} a day	${Insert amount equal to 25% of Medicare Part A deductible} a day	$0
91st day and after:			
- While using 60 lifetime reserve days	All but ${Insert amount equal to 50% of Medicare Part A deductible} a day	${Insert amount equal to 50% of Medicare Part A deductible} 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 ${Insert amount equal to 12.5% of Medicare Part A deductible} a day	Up to ${Insert amount equal to 12.5% of Medicare Part A deductible} a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints [Additional amounts]	$0 [100%]	3 pints [$0]	$0 [$0]

Additional amounts	*100%*	*$0*	*$0*
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

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

SERVICES	MEDICARE PAYS	*{AFTER YOU PAY ${Insert amount of Plan G high deductible} DEDUCTIBLE, **}* PLAN PAYS	*{IN ADDITION TO ${Insert amount of Plan G high deductible} 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 ${Insert amount of Medicare Part B deductible} of Medicare-approved amounts*	$0	$0	${Insert amount of Medicare Part B deductible} [Part B Deductible] *(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 ${Insert amount of Medicare Part B deductible} of Medicare-approved amounts*	$0	$0	${Insert amount of Medicare Part B deductible} [Part B Deductible] *(Unless Part B deductible has been met)*
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES-TESTS FOR	100%	$0	$0

DIAGNOSTIC SERVICES			
PARTS A & B			
SERVICES	MEDICARE PAYS	*{AFTER YOU PAY ${Insert amount of Plan G high deductible} DEDUCTIBLE, **}* PLAN PAYS	*{IN ADDITION TO ${Insert amount of Plan G high deductible} DEDUCTIBLE, **}* YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First ${Insert amount of Medicare Part B deductible} of Medicare-approved amounts*	$0	$0	${Insert amount of Medicare Part B deductible} [Part B Deductible] *(Unless Part B deductible has been met)*
Remainder of Medicare-approved amounts	80%	20%	$0
OTHER BENEFITS-NOT COVERED BY MEDICARE			
SERVICES	MEDICARE PAYS	*{AFTER YOU PAY ${Insert amount of Plan G high deductible} DEDUCTIBLE, **}* PLAN PAYS	*{IN ADDITION TO ${Insert amount of Plan G high deductible} 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

I. — L (text unchanged)

.31 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.

A. General Standards.

(1) A policy or certificate that provides coverage of the Medicare Part B deductible may not 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.

(2) Medicare supplement policies and certificates delivered or issued for delivery to individuals eligible for Medicare before January 1, 2020 remain subject to the requirements of Regulation .28 of the chapter.

(3) Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020 are subject to the requirements of Regulation .28 of this chapter, except as stated in §§B and C of this regulation.

(4) 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.

B. Make-up of 2020 Standardized Benefit Plans

(1) Standardized Medicare supplement benefit Plan C is re-designated as Plan D and shall include the benefits contained in Regulation .28H(3) of this chapter except for coverage for 100 percent or any portion of the Medicare Part B deductible.

(2) Standardized Medicare supplement benefit Plan F is re-designated as Plan G and shall include the benefits contained in Regulation .28H(5) of this chapter except for coverage for 100 percent or any portion of the Medicare Part B deductible.

(3) Standardized Medicare Supplement Benefit Plan G With High Deductible.

(a) Standardized Medicare supplement benefit Plan F with High Deductible is re-designated as Plan G with High Deductible.

(b) Standardized Medicare supplement benefit Plan G with High Deductible shall include the benefits contained in Regulation .28H(6) of this chapter except for coverage for 100 percent or any portion of the Medicare Part B deductible.

(c) The Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual Plan G high deductible.

C. In the case of an individual newly eligible for Medicare on or after January 1, 2020, the reference to Plans C or F in Regulation .28D(2) of this chapter is deemed a reference to Plans D or G, respectively.

D. On or after January 1, 2020, the standardized benefit plan described in §B(3) of this regulation may be offered to an individual who was eligible for Medicare prior to January 1, 2020 in addition to the standardized plans described in Regulation .28H of this chapter.

E. For purposes of Regulation .09-1E of this chapter, in the case of an individual newly eligible for Medicare on or after January 1, 2020, any reference to Plans C or F (including F With High Deductible) shall be deemed to be a reference to Plans D or G (including G With High Deductible) respectively.

ALFRED W. REDMER, JR.
Insurance Commissioner

Title 36
MARYLAND STATE LOTTERY AND GAMING CONTROL AGENCY

Notice of Proposed Action

[18-300-P]

The Maryland State Lottery and Gaming Control Agency proposes to:

(1) Amend Regulations **.01** and **.03—.06** under **COMAR 36.01.01 General**;

(2) Amend Regulations **.01—.06** under **COMAR 36.01.02 Administrative Procedures**;

(3) Amend Regulations **.01—.07** under **COMAR 36.01.03 Voluntary Exclusion and Responsible Gaming**;

(4) Amend Regulation **.01** under **COMAR 36.02.01 General**;

(5) Amend Regulations **.01**, **.02**, **.05**, **.06**, and **.10** under **COMAR 36.02.02 Retailer Licensing**;

(6) Amend Regulations **.01** and **.02**, adopt new Regulation **.03**, and amend and recodify existing Regulations **.03—.10** to be Regulations **.04—.11** under **COMAR 36.02.03 Retailer Requirements**;

(7) Amend Regulations **.02—.05** under **COMAR 36.02.04 Common Provisions for All Lottery Games**;

(8) Amend Regulations **.01** and **.02** under **COMAR 36.02.05 Specific Game Provisions**;

(9) Amend Regulations **.01**, **.04—.06**, **.08**, **.11**, **.12**, **.15**, and **.18** under **COMAR 36.02.06 Claims Procedures**;

(10) Amend Regulation **.02** under **COMAR 36.02.07 Unclaimed Lottery Prizes**;

(11) Amend Regulations **.01** and **.06—.08**, adopt new Regulation **.02**, repeal existing Regulation **.04**, amend and recodify existing Regulation **.03** to be Regulation **.04**, and recodify existing Regulation **.02** to be Regulation **.03** under **COMAR 36.02.08 Voluntary Assignment of Monetary Prizes**;

(12) Amend Regulation **.02** under **COMAR 36.03.01 General**;

(13) Amend Regulation **.15** under **COMAR 36.05.02 Table Game Equipment**; and

(14) Adopt new Regulations **.01—.15** under a new chapter, **COMAR 36.09.01 Fantasy Competition**, under a new subtitle, **Subtitle 09 Online Fantasy Competition**.

This action was considered at the Maryland Lottery and Gaming Control Commission open meeting held on September 20, 2018, notice of which was given pursuant to General Provisions Article, §3-302(c), Annotated Code of Maryland.

Statement of Purpose

The purpose of this action is to:

(1) Under 36.01.01, revise the definition of "final action on a license denial" to include the option of the Commission to delegate a hearing to the OAH; consolidate the definition of "state obligations" into one chapter; and update citations pertaining to the Central Collection Unit (CCU);

(2) Under 36.01.02, clarify administrative procedures of the Agency and Commission;

(3) Under 36.01.03, add instant bingo facilities with more than 10 machines to the gaming venues from which an individual may self-exclude; codify casinos' existing practice of filing a criminal trespass charge, consistent with COMAR 36.03.06; and add changes to reflect the Agency's current practice of sending notices related to the voluntary exclusion list by email as well as mail;