ATTACHMENT #1 (Rev. 03-2010)

MEDICARE SELECT CHECKLIST

A Medicare Select program is a Medicare Supplement policy or certificate which is permitted to use a restricted network provision, meaning that the payment of benefits can be conditioned, in whole or in part, on the use of network providers.

Medicare Select Policies/Certificates should also comply with:
806 KAR 17:570
KRS 304.14-500 – KRS 304.14-550
KRS 304.17-050 – KRS 304.17-160

Medicare Select Plan of Operation

A Medicare Select issuer shall not issue a Medicare Select policy until its plan of operation is approved pursuant to 806 KAR 17:570 Section 11and KRS 304.14-120

The Plan of Operations shall include at least the following (Subsection 4):

(1) Evidence that services subject to restricted network provisions are available and accessible through network providers

- -- Services can be provided by network providers with reasonable promptness with respect to geographic location and after-hour care
  - -- Geographic availability shall not be more than sixty (60) miles from insured's residence
- -- There is sufficient number of providers to
  - -- Adequately deliver all services subject to restricted network provisions and;
  - -- To make appropriate referrals
- -- There are written agreements with network providers which describe specific responsibilities.
- -- Emergency care is available 24 hours a day, 7 days per week
- -- The written agreements with network providers prohibit balance billing or seeking recourse from a Medicare Select subscriber (other than charges set forth in the policy or certificate).

(2) A statement or map clearly describing the service area

(3) A description of the grievance procedure

(4) A description of the quality assurance program, including:
-- The formal organizational structure
-- The written criteria for selection, retention, and removal of network providers
--The procedures for evaluating quality of care 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 to comply with the disclosure requirements described in Subsection

(7) Any other information requested by the commissioner

(8) Except for changes to the list of network providers, any proposed changes to the Plan of Operation must be filed prior to implementing the change. Changes will be considered approved after 30 days unless they are specifically disapproved (Subsection 5)
-- An updated list of network providers shall be filed at least quarterly.

Specific Medicare Select Policy Provisions

(1) A Medicare Select policy or certificate cannot restrict payment for covered services to non-network providers if (Subsection 6)
-- The services are for symptoms requiring emergency care or are immediately required for unforeseen illness, injury, or condition;
-- If it is not reasonable to obtain such services through a network provider or;
-- No network provider within sixty (60) miles of insured's residence

(2) A Medicare Select policy or certificate shall provide for full payment for covered services that are not available through a network provider (Subsection 7)

(3) An issuer shall make full and fair disclosure in the writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant (Subsection 8). The disclosure shall include:

- -- An outline of coverage sufficient to permit applicant to compare cover and premiums of Medicare Select policy with
  - -- Other Medicare supplement policies offered by insurer
  - -- Other Medicare Select policies
- -- A description (including address, phone number, and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers
- -- 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 policy, expenses incurred when using out-of-network providers shall not count toward the out-of-pocket annual limit contained in Plans K and L)
- -- A description of coverage for emergency and urgently needed care and out-of-service area coverage
- -- A description of limitations on referrals to restricted network providers and to other providers
- -- A description of the policyholder's right to purchase any other Medicare Supplement policy or certificate offered by the issuer
- -- A description of the Medicare Select issuer's quality assurance program and grievance procedure

(4) Prior to the sale the insurer shall obtain a signed and dated form by the applicant stating that the applicant has received the information required above (required by Subsection 8) and understands the restrictions of the Medicare Select policy

(5) An insurer shall have and use procedure for hearing and resolving complaints and grievances from subscribers (Subsection 10)

- -- Grievance procedure shall be described in the policy and outline of coverage
- -- Upon issuance the insurer shall provide detailed information describing how a grievance may be registered.
- -- the insurer shall report no later than March 31st to eh commissioner regarding its grievance procedure, including number of grievances filed in the past year and summary of the subject, nature and resolution.

(6) Upon initial purchase the insurer shall make available the opportunity to purchase a Medicare supplement policy offered by insurer (Subsection 11)

(7) At request of insured, a Medicare Select insurer shall make available opportunity to purchase a Medicare supplement policy with comparable or lesser benefits which does not contain restricted network provisions. These policies shall be available without requiring evidence of insurability after the Medicare Select policy has been in force for six (6) months (Subsection 12)

-- The Medicare supplement policy will be considered to have comparable or lesser benefits unless it contains one or more of the following significant benefits not included in the Medicare Select policy:

-- Medicare Part A deductible
-- At-home recovery services
-- Part B excess charges

(8) Medicare Select policies shall provide for continuation of coverage in event the secretary discontinues the Medicare Select program due to failure or it is not reauthorized. (In this event, the same opportunity is provided to the insured as is required under Subsection 12)

(9) An insurer shall comply with reasonable requests for data made by state or federal agencies, including the United State Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.