GROUP AND INDIVIDUAL MEDICARE SUPPLEMENT INSURANCE FILING CHECKLIST (Rev. 11/2009) (806 KAR 17:570)

Complies with: Required Policy Provisions KRS 304.17-050 – KRS 304.17-160
Requirement s set forth KRS 304.14-500 – KRS 304.17-550
806 KAR 17:010 – Returning unearned premium at death
806 KAR 17:050 – Medicaid as first payer prohibited

806 KAR 17:570

Policy Definitions and Terms – can NOT be more restrictive than outlined (Section 4)

(1) ”Accident”, “accidental injury”, accidental means”
(2) ”Activities of daily living”
(3) “At-home recovery visit”
(4) “Benefit period”
(5) “Care Provider”
(6) “Convalescent nursing home”, “extended care facility”, or “skilled nursing facility”
(7) “Emergency care”
(8) “Home”
(9) “Hospital”
(10) “Medicare”
(11) “Medicare eligible expenses”
(12) “Physician”
(13) “Pre-existing condition”
(14) “Sickness”

Policy Provisions (Section 5)

(1) Must not contain limitation or exclusions more restrictive than Medicare
(2) Must not contain probationary or elimination period
(3) Must not use waivers to exclude, limit or reduce coverage or benefits for specifically named pre-existing diseases or physical conditions
(4) Shall not contain benefits that duplicate benefits provided by Medicare
(5) Medicare supplement products with prescription drug coverage not to be sold after December 31, 2005

Minimum Benefit Standards Pre-Standardized Medicare Supplement policies issued **PRIOR** to **January 1, 1992** (Section 6)

Benefit Standards for 1990 Standardized Medicare Supplement policies issued on or **after January 1, 1992 – June 1, 2010 (**Section 7)
General Standards:

(1) Pre-existing condition can NOT be more restrictive than six (6) months before effective date
(2) Shall not contain probationary or elimination periods ; or indemnify against losses from sickness on different basis as losses from accidents
(3) Must change automatically to coincide with changes in Medicare

(4) Shall not terminate coverage of spouse because of termination (except for nonpayment of premium)
(5) Shall be guaranteed renewable
(6) Termination of policy during continuous disability
(7) Suspension of coverage (up to 24 months) and reinstitution of coverage

(2) Standards for Basic (Core) Benefits Plans "A" thru "J"
(3) Standards for Additional Benefits Plans "B" thru "J"
(4) Standards for Plans "K" and "L"

Benefit Standards for 2010 Standardized Medicare Supplement policies effective on or after **June 1, 2010** (Section 8)

General Standards: (Same as Section 7(1))
(2) Standards for Basic (Core) Benefits Plans A, B, C, D, F, High Deductible F, G, M and N
(3) Standards for Additional Benefits Plans B, C, D, F, High Deductible F, G, M and N (as provided in Section 10)

Standard Medicare Supplement policies issued on or after January 1, 1992 with effective date **PRIOR** to **June 1, 2010 (**Section 9)

(1) Shall make available a policy form containing only the basic core benefits
(2) Groups, packages or combinations shall not be offered in Kentucky except as permitted (Subsection 9(7) and Section 11)
(3) Benefit plans shall be uniform in structure, language, designation and format (plans A thru L) and conform to definitions in Section 9. Each benefit shall be structured in accordance with the format provided (Section 7(2), (3), (4)) and list benefits in order shown
(4) Make-up of Benefit Plans

Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan policies with effective date on or after **June 1, 2010** (Section 10)

(1) Shall make available a policy form containing only basic core benefits and if making available any of the additional benefits (described in Section 8(3)) must also make available at least Plan C or Plan F ((1)(b))
(2) Groups, packages or combinations shall not be offered in Kentucky except as permitted (Subsection 10(6) and Section 11)
(3) Benefit plans shall be uniform in structure, language, designation and format as provided in Sections 8(2) and 8(3)) or for plans K or L Sections 10(5)(h) or (i)
(4) 2010 Standardized Benefit Plans (Section 10 (5))

Open Enrollment (Section 12)

(1) Guarantee issue during the first six (6) months of eligibility in Medicare Part B (65 or older)
(2) Each Medicare supplement policy currently available from an insurer shall be made available to all applicants who qualify regardless of age
(3) Prior coverage credit during open enrollment
(3) Pre-existing condition exclusions allowed during first six (6) months

Guaranteed issue for Eligible Persons (Section 13)

(1) Guaranteed Issue
(2) May not discriminate in pricing because of health status, claims experience, receipt of health care or medical condition; or impose an exclusion of benefits based on preexisting condition
(3) An eligible person
(4) Guarantee Issue time periods
(5) Products to which eligible persons are entitled
(6) Notification provisions

Standards for Claims Payment (Section 14)

(1) Furnish enrollee with card listing policy name, number and mailing address for notices from Medicare upon enrollment

Lost Ration Standards and Refund or Credit of Premium (Section 15)

(1) Loss Ratio Standards
    (1) 75% for group
    (2) 65% for individual
(2) Refund or Credit Calculation
    (1) Insurers shall collect and file with the Commissioner by May 31 of each year data applicable to reporting form HL-MS-1
(3) Annual filing of Premium Rates – rates, rating schedule, supporting documentation

Required Disclosure Provision (Section 18)

(1) General Rules
    (1) Must include renewal or continuation provision on first page (including right to change premiums)
    (2) Endorsements must be signed by insured if separate premium is charged (additional premiums in connections with riders/endorsements must be set forth in policy)
    (3) Must not provide for payment or benefits based on standards described as "usual and customary", "reasonable and customary", etc.
    (4) Limitations on pre-existing conditions must be in a separate paragraph and labeled "Preexisting Condition Limitation"
    (5) Thirty-day right to return policy prominently printed on first page
    (6) Must provide "Guide to Health Insurance for People with Medicare" upon application
(2) Notice Requirements
    (1)Thirty-day notice of modifications made to Medicare Supplement policies/certificates and premium adjustments (shall not contain solicitations)
(3) Outline of Coverage Requirements
    (1) Must be provided at time of application
    (2) NOTICE statement (4)(b) no less than 12 point type immediately above the company name
    (3) Shall consist of four parts:
        Cover page
        Premium rate information
        Disclosure pages
        Charts for all plans being offered

(4) Outline shall be in language and format as HL-MS-4

(4) Notice Regarding Policies that are not Medicare Supplement Policies

(1) Must provide notify insured eligible for Medicare if policy is not Medicare Supplement

(2) Notice should be printed or attached to 1st page of Outline of Coverage or Policy and contain "THIS POLICY IS NOT A MEDICARE SUPPLEMENT . . ." statement

(3) Shall use applicable statement as provided in HL-MS-3

Requirements for Application Forms and Replacement Coverage (Section 19)

(1) Comparison statement – HL-MS-5, must be presented at time of application

(2) Agents shall:

Sign the comparison statement

Obtain signature of applicant

Send comparison statement to insurer and attach copy to replacement policy

(2) Application

(1) Questions on HL-MS-6

(2) Statements - HL-MS-7

(3) Agents list any other policies sold; policies still in force; policies sold within last 5 yrs

(4) Applicants not required to answer questions regarding health status (includes smoker/nonsmoker and height and weight) Section 13(1)

(3) Replacement Form - HL-MS-8

(1) Signature of applicant and agent

Filing Requirements for Advertising and Policy Delivery (Section 20)

(1) Insurer shall provide copy of any advertisement intended for use for review prior to use. Does not require 'approval' prior to use, but shall not be used if 'disapproved.'

(2) Signed and dated delivery receipt from insured if Medicare supplement is not delivered by mail

Medicare Select Policies and Certificates (Section 11) – see Attachment #1

Filing and Approval of Policies and Certificates and Premium Rates (Section 16)

(1) Shall not deliver or issue for delivery any policy or certificate in Kentucky unless it has been filed and approved (in accordance with KRS 304.14-120)

(2) Shall not use or change premium rates unless rates, rating schedule and supporting documents have been filed and approved (in accordance with KRS 304.14-120)

(3) May offer up to four (4) additional policy/certificate forms of same type for only one of the following reasons:

- Inclusion of new or innovative benefits
- Addition of direct response or agent marketing methods
- Addition of guaranteed issue or underwritten coverage
- Offering coverage to individuals eligible for Medicare by reason of disability

(4) May discontinue availability of policy if provided, in writing, to Commissioner at least thirty (30) days prior to discontinuing.

(6) After discontinuing a policy form cannot file for approval new policy form of the same type for five (5) years

(7) The sale or transfer of Medicare supplement business shall be considered a discontinuance
(8) A change in the rating structure or methodology shall be considered a discontinuance

Permitted Compensation Arrangements (Section 17)

Standards for Marketing (Section 21)

Appropriateness of Recommended Purchase and Excessive Insurance (Section 22)

Reporting of Multiple Policies (Section 23)
(1) HL-MS-2

Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates (Section 24)
(1) If a Medicare Supplement policy is to replace another Medicare supplement policy an insurer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in new policy to the extent time was spent under original
(2) If Medicare supplement policy replaces another Medicare Supplement policy that 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.

Prohibition Against use of Genetic Information and Requests for Genetic Testing (Section 25)
(1) Shall not deny or condition the issuance or effectiveness of policy or certificate based on genetic information
(2) Shall not discriminate in pricing, adjustment of premium rates on basis of genetic information
(3) Insurer shall not request or require to undergo genetic test
(4) Insurer shall not request, require or purchase genetic information for underwriting purposes
(5) Insurer shall not request, require or purchase genetic information prior to an enrollment in connection to enrollment