

**Standard Medicare Supplement Insurance Forms
AND
Medicare "Select" Insurance Forms Checklist
For Policies, Certificates and Supporting Forms that are issued on or after
1.1.2020
Last Update: 3.13.19**

INTRODUCTION

The Department has created this checklist as a tool to guide you in making a Medicare Supplement Policy Forms filing of 2020 Policy Forms issued effective on or after January 1, 2020. Please refer to the actual statutes and regulations (Accident and Health Filing Reform Act, 40 P.S. §3801.101 et. seq., Medicare Supplement Insurance Act, 40 P.S. §3101 et. seq., Medicare Supplement Insurance Minimum Standards, 31 Pa. Code §89.770 et. seq.) for complete compliance details.

The System for Electronic Rate and Form Filing (SERFF) should be used for making an Electronic Filing. Electronic SERFF Filings utilize the "Electronic Fund Transfer (EFT)" mode within SERFF.

FILING SUBMISSION REQUIREMENTS

Filings must include the following to be considered a complete filing:

- Transmittal Letter
- Certification of Plans A, B, and D or G
- Final Printed Policy Forms (incl. policy schedule of benefits)
- Application Form
- Outline of Coverage Form
- Notice Regarding Replacement Form
- Notice of Benefit Modification and Premium Adjustment Form referred to as Notice of Change Form *for each Medicare Supplement Plan*
- Certification of Compliance with the Electronic Transactions Act if the forms are to be used electronically.

The absence of the above components may result in a partial review or total rejection of the filing. The Application Form, Notice Regarding Replacement, Outline of Coverage, and Certification of Plans A, B, and D or G, should be included in your Plan A submission. All other Plans may reference the location of these forms as included in the Plan A filing. Do not submit these forms with each Plan.

General Instructions: Please take a moment and review the General Instructions for making a filing to the Pennsylvania Insurance Department Bureau of Life, Accident and Health Insurance. The Bureau requires separate form and rate filings. A new Sub-Type of Insurance (Sub-TOI) Code is available.

The Life, Accident and Health Bureau does not accept multiple company filings. If the same document is to be filed for more than one Company, the filing must be submitted as a separate filing for each Company.

The PDF Pipeline must work on all attachments. The filer must ensure that the PDF Pipeline works before submission of the filing to the Insurance Department. Filings with attachments not compatible with the PDF Pipeline will be rejected. Currently, attachments larger than 3MB cannot be submitted via the PDF Pipeline. Please contact the SERFF Help Desk at 816-783-8990 for assistance.

Forms to be approved by the Department must be uploaded under the "Forms" tab in the SERFF Form filing. Do not upload these forms under the "Supporting Documents" tab. Only supporting documents and informational forms not submitted for approval are to be uploaded on the Supporting Documents tab.

Rates and Actuarial Data are to be uploaded under the "Rates" Tab and not under the supporting documents tab.

Provide the Corresponding SERFF Tracking Number under the General Information Tab of your SERFF Filing: Separate and Corresponding Form or Rate filings must be linked to each other. Under the General Information Tab of the SERFF Filing, indicate the SERFF Tracking Number of the Corresponding separate Form or Rate filing that is associated with the SERFF Form or Rate you are filing. Failure to link separate corresponding SERFF filings with each other may cause the filing to be rejected or cause a delay while you make the necessary post-submission addition of the Corresponding SERFF Tracking Number.

Retaliatory filing Fees Only - [40 P.S. § 50] – Any filing fee as required by the retaliatory requirements of Section 212 of the Insurance Department Act

Transmittal Letter - [31 Pa. Code §89b.5] – The Transmittal Letter (a.k.a. Submission Letter) communicates to the Department the intentions of the filer regarding the Forms filing. See "Transmittal Letter Requirements" in this check-list for more details.

Advertisements – Advertisement filed with the Department must adhere to [31 Pa. Code §51 and 31 Pa. Code §89.785] and should be filed separately.

Forms Filing Requirements [31 Pa. Code §89b.4] – see "Form Requirements" in this check-list for more details.

Actuarial/Premium Rate Filing - Rate filings must be submitted to the Department separate from any corresponding form filing.

Statement of Variability - [31 Pa. Code §89b.11 (e) and 31 Pa. Code §89b.4 (b)] - Provide an explanation of the variability of any information appearing in the policy, or other form which is intended to be variable. All variable text shall be [bracketed] to clearly denote variability. In the event multiple forms are variable, please segregate the explanation of variability applicable to each form.

Transmittal Letter Required Components

It is necessary to provide a clear and concise transmittal cover letter that provides the following information:

Representative/Insurer Identity & Authorization to File [31 Pa. Code §89b.4 (f)] – Identify the insurer and the person authorized to make the filing. If the filing is being submitted on behalf of the insurer, a letter of authorization from the Insurance Company must accompany the filing that authorizes the third party to make the filing.

Forms List [31 Pa. Code §89b.5] - The Transmittal Letter must include an accurate list of the forms submitted for review and/or approval. The list must contain:

Form Number – Identify the form number of each submitted form. If the form is other than a policy or contract, disclose the form number of the policy or contract with which it will be used. If the form will be used with a prior approved policy form, provide the date the form was approved by or filed with the Department. Note: Please provide the SERFF Tracking Number and date the form was previously approved or insert a copy of the form showing the Department's approval stamp.

Form Description – Describe the type of form - (E.g. policy, contract, certificate, rider, endorsement, amendment, agreement, application, insert page or other general type).

Marketing Method – Describe the marketing method to be used in conjunction with the form. (E.g. direct response or producer marketing policy forms or solicitation of individuals participating in a legally recognized franchise group). 31 Pa. Code §89.781(d) explains the restrictions regarding the issuance of multiple Medicare Supplement Insurance policy forms. Only one policy form may be offered per marketing method.

New or Replacement Form [31 Pa. Code § 89b.4, 31, Pa. Code §89(b).5 and 31 Pa. Code §89b.11] Include a statement indicating if the form is new or replacing a previously approved form.

If the form is replacing a previously approved form, the following requirements must be met:

- Provide the form number of the form to be replaced.
- Provide the date that the form was approved or filed with the Department.
- Provide a unique form number in the lower left-hand corner of the replacement forms.
- Provide the SERFF tracking number of the previously approved form.
- Provide a description of the changes made to the form to be replaced. The Department requires a highlighted copy indicative of the changes be submitted with the Forms file or a red line copy submitted under the Supporting Documents tab of SERFF.

□ **Innovative Features** [31 Pa. Code §89b.5(4)] – Any form containing any provision, condition, feature or concept that departs from those generally used by the industry and that could be construed as new, innovative, uncommon or unusual, must be accompanied by a statement to that effect and an explanation of the specific purpose of the provision, condition, feature or concept, as well as a named person within your organization and their contact information. The Department will contact the designated person if more detailed information is needed.

□ **Insert Page Requirements** [31 Pa. Code §153.2] – Insert pages may be used to modify or revise previously approved policies. The use of the insert page will not result in a change in the form number appearing in the lower left corner of the first page of the policy. The form number and approval date of the policy being modified by the insert page should be provided. A company officer should certify that after approval of the insert page, the policy will be issued only with the insert pages and the replaced page(s) will no longer be issued with the policy. An explanation of the necessity for the insert page should be included. The inclusion of the insert pages may not cause the policy description to be inaccurate or misleading.

An Actuarial/Premium Rate filing must be filed as necessary to support changes of benefits or other items that have an actuarial impact.

Form Filing Requirements

For approval purposes, the forms must be presented to the Department in the final printed form intended to be issued by the Company. Incomplete or draft forms are not acceptable.

Section I: Certification, Readability and General Requirements

Medicare Supplement Insurance Forms filing requires specific certification as captured below and must meet the following readability standards:

□ **Certification of Plans A, B and D OR G** [31 Pa. Code §89.776a (2) and 31 Pa. Code §89.777c (b) (1 and 2)] – The Company must certify that Plan A, B and D or G are being made available in the Commonwealth of Pennsylvania as required by regulation. Filings that do not contain the required Plans will be rejected.

An issuer may offer, with the approval of the Commissioner, up to three additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan. These additional forms may include one or more of the following three variations. “Type” means a policy, a group policy, an individual Medicare Select Policy or a group Medicare Select Policy.

Forms with only these variations will be regarded as new policy forms under each type: (i) The inclusion of new or innovative benefits. (ii) The addition of either direct response or producer marketing methods. (iii) The addition of either guaranteed issue or underwritten coverage.

Electronic Transactions [73 P.S. Section 2260.101 et. seq.] – It is permissible for Companies to offer Insurance Products electronically. This includes but is not limited to telephonic applications which are subject to voice recording, internet/website applications and electronic or paper applications that require electronic signatures. The rights of consumers under existing laws need to be protected and preserved; therefore, the insurer must comply with the Pennsylvania Electronic Transactions Act [73 P.S. §§2260.101 et seq.]. Please review these requirements and provide Certification to the Department that the forms that will be subject to electronic use within this filing are compliant with Electronic Transaction Act. (See Section V for details on this Act).

Certification of Discontinuance [31 Pa. Code §89.781(e)] – A Company may discontinue the availability of a policy or certificate form if the issuer provides to the Commissioner in writing its decision at least 30 days prior to discontinuing the availability of the form. After receipt of the notice by the Department, the issuer may not offer for sale the policy form in this Commonwealth for 5 years after the issuer provides notice to the Department.

General Readability [31 Pa. Code § 89b.11 (f) and 31 Pa. Code § 89b.4 (b)] - Forms shall be clearly legible, concise, accurate and consistent.

Type (Font) [40 P.S. §752(A)(4), 31 Pa. Code §89.783(d)(3) and 31 Pa. Code §89.784(4)] - Each form shall be presented in at least 10 point type with the exception of the Outline of Coverage and Notice Regarding Replacement which are to be 12 point.

Prominence [40 P.S. §752(A)(4)] - The style, arrangement and overall appearance of the policy shall give no undue prominence to any portion of the text of the policy or to any endorsements or riders.

Variability [31 Pa. Code §89(b).11(e)] - The blank spaces of each form, except an application, shall be filled in with hypothetical data to indicate the purpose of the form. This data shall be realistic and consistent with the other contents of the form. Information appearing in a form, except an application, which is variable shall be [bracketed] to denote variability.

SECTION II: POLICY FORM REQUIREMENTS

COVER PAGE REQUIREMENTS

Company Name & Address, Logo, Signatures [31 Pa. Code §89b.11 (a) and 40 P.S. § 440] - (1) The full corporate name of the insuring company shall appear prominently on the first page of the policy. (2) A marketing name or logo may also be used on the first page of the policy provided that the marketing name or logo does not distract from the identity of the insuring company or the complete and clear description of the category of coverage. (3) The insuring company address consisting of at least a city and state shall appear on the first page of the policy. (4) Two signatures of authorized company officers executing the contract shall appear on the first page of the policy.

Free Look [31 Pa. Code §89.783(a) (5)] - The policy shall contain a right to examine provision that shall appear on the cover page of the policy. This must include the address of company so that policy can be returned directly to the Company.

Form Number [40 P.S. § 752(A) (6) and 31 Pa. Code 89b.11 (b)] - A form identification number shall appear at the bottom of the policy. The form number shall be adequate to distinguish the form from all others used by the insurer and placed in the lower left-hand corner of the document.

Description of Coverage [31 Pa. Code 89b.11(c) and 31 Pa. Code 89.783(a) (1)] - The policy shall contain a brief description that shall appear prominently on the cover page of the policy or is visible without opening the policy. The brief description shall contain at least the following information: (a) A caption of the general type of form and type of coverage provided identified by the letter of the standardized plan; for example, Medicare Supplement Standard Policy Plan A. Any marketing name should be presented clearly to not detract from the actual description of coverage. For example, Medicare Supplement Standard Policy Plan A, marketed as ".....".

Participating or Non-Participating [31 Pa. Code §89b.11(c) (3)] - Disclose whether or not the policy is participating or non-participating with regard to paying dividends to policyholders.

Notice to Buyer on the first page of the policy - [31 Pa. Code §89.786(a) (3)] - The policy shall display a notice that states "Notice to buyer: This policy may not cover all of your medical expenses."

Renewability – Guaranteed Renewable [31 Pa. Code §89.776(1) (v) and 31 Pa. Code §89.783(a) (1) and (b) (1)] - Each Medicare supplement policy shall be guaranteed renewable. Medicare supplement policies shall include a renewal or continuation provision. This provision shall be appropriately captioned and shall appear on the first page of the policy and include the insurers right to change premiums, and if applicable, any automatic renewal premium increases based on age (attained) and give 30 days prior notice of premium change.

Notice of Accuracy Provision - If the application contains medical questions [31 Pa. Code §89.783(a) (5)]

Applicable to Fraternal Benefit Society Only - Refer to Subchapter D of 31 Pa. Code § 89 ADDITIONAL REQUIREMENT FOR FRATERNAL BENEFIT SOCIETIES.

MISCELLANEOUS REQUIREMENTS

Pre-existing Conditions [31 Pa. Code §89.776a (1) (i)] - (1) - If a policy contains a pre-existing condition exclusion or limitation, it must be shown as a separate paragraph [31 Pa. Code §89.783(a)(4)]. (2) The policy may not exclude or limit benefits for losses

incurred more than 6 months from the effective date of the policy and a pre-existing condition may not be defined more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of the policy.

Suspension by Policyholder [31 Pa. Code §89.776a (1) (vii)] - A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder or certificateholder for the period so specified in Regulation.

Extension of Benefits and Termination of Coverage [31 Pa. Code §89.776a (1) (vi)] - Termination of a Medicare supplement policy or certificate shall be without prejudice to a 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, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss. A Medicare supplement policy or certificate may not 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.

Exclusions and Limitations [31 Pa. Code §89.774(a, b and c)] - A policy may not be advertised, solicited or issued for delivery in this Commonwealth as a Medicare supplement policy if the policy contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

GENERAL PROVISIONS IN THE POLICY FORM:

Required Provisions - 40 P.S. Section 753 (A)

Entire Contract; Changes [40 P.S. §753(A) (1)] - (1) The policy shall contain a provision regarding what constitutes the entire contract between the insurer and the policyholder. (2) If the application is to be a part of the policy, the entire contract provision shall state that the application is a part of the policy. (3) No agent has authority to change the policy or to waive any of its provisions.

Time Limit on Certain Defenses [40 P.S. §753(A) (2)] - (1) The policy shall contain a provision regarding time limits on certain defenses. (2) The contestable period shall be no greater than 3 years from the date of policy issue. (3) Coverage may be contested based on a statement contained in an application made a part of the policy if the issuing company expects to rely on an application to contest the policy, the company must attach or otherwise make the application a part of the policy. (4) The policy may only include the following exception to the time limit on certain defenses provision: non-payment of premium or fraudulent misstatement.

Grace Period [40 P.S. §753(A) (3)] - (1) The policy shall contain a grace period provision and include the conditions of the provision. (2) A minimum of 30-days grace

period shall be provided for the payment of any premium due except the first. (3) The coverage shall continue in force during the grace period.

Reinstatement [40 P.S. § 753(A) (4)] - (1) The policy shall contain a reinstatement of the policy for nonpayment of premiums provision and include the conditions of the reinstatement. (2) Application/evidence of insurability may be required.

Notice of Claim [40 P.S. §753(A)(5) and 31 Pa. Code §89.779(a)(1)] - (1) The policy shall contain a notice of claim provision that provides for written notice of the claim by the policyholder within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. (2) The provision shall contain an address to which the policyholder shall submit the notice of claim.

Claim Forms [40 P.S. §753(A) (6) and 31 Pa. Code §89.779(a) (1)] - The policy shall contain a claim forms provision which provides the following: (a) The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. (b) If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss.

Proof of Loss [40 P.S. §753(A) (7) and 31 Pa. Code §89.779(a) (1)] - (1) The policy shall contain a proof of loss provision and include the conditions of the provision. (2) The provision shall provide that notice to the insurer be made within 90 days of the date of such loss. (3) The provision shall provide that failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time.

Time of Payment of Claims [40 P.S. §753(A) (8)] - (1) The policy shall contain a time of payment of claims provision which shall provide for the immediate payment upon receipt of written proof of loss.

Payment of Claims [40 P.S. §753(A) (9)] - The policy shall contain a payment of claims provision that includes conditions for payment of claims in the event where there is no beneficiary designation.

Physical Examinations [40 P.S. §753(A) (10)] - (1) The policy shall contain a physical examination provision. (2) The provision shall indicate that the insurer at its own expenses shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim.

Legal Actions [40 P.S. §753(A) (11)] - (1) The policy shall contain a legal actions provision. (2) The provision shall indicate that no action at law or in equity may be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. (3) The provision shall indicate that no such action may be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

See 40 P.S. §753(B) for other provisions that may or may not appear.

BENEFIT PROVISIONS AND STANDARDS

Definitions within the Policy [31 Pa. Code §89.772, 31 Pa. Code §89.773 and 48 Pennsylvania Bulletin 5601] - Definitions should follow regulation.

Benefit Standards (January 1, 2020 and after) [31 Pa. Code §89.776a and 31 Pa. Code §89.777c] - The policy provisions shall comply with the standards provided. Health Care Practitioners Medicare Fee Control Act (35 P.S. §§449.31-449.36) prohibiting balance billing between the actual charge and the Medicare approved Part B charge. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit Plans A—N listed in this section (89.777c(d)) and conform to the definitions in § 89.773 (relating to policy definitions and terms). Each benefit shall be structured in accordance with the format in §§ 89.776a (2) and (3) and list the benefits in the order shown in that section.

Core Benefits (required for all plans):

Basic Core Benefits includes -

- Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from day 61 through day 90 in any Medicare benefit period.
- 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. –
- Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 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. –
- Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells as defined under Federal regulations, unless replaced in accordance with Federal regulations. –
- Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible. –
- Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

Plan A Benefit Plan - All core benefits as listed above.

Plan B Benefit Plan: An issuer shall also offer a policy or certificate to prospective insureds meeting the Plan B benefit plan. Standardized Medicare supplement benefit Plan B shall include the following in addition to the core benefits listed above:

- 100% of the Medicare Part A deductible.

Plan C Benefit Plan: (not available to individuals newly eligible for Medicare on or after 1.1.20)

Standardized Medicare supplement benefit Plan C shall include the following in addition to the core benefits listed above:

- 100% of the Medicare Part A deductible,
- Skilled nursing facility care,
- 100% of the Medicare Part B deductible and
- Medically necessary emergency care in a foreign country.

Plan D Benefit Plan:

Standardized Medicare supplement benefit Plan D shall include the following in addition to the core benefits listed above:

- 100% of the Medicare Part A deductible,
- Skilled nursing facility care and
- Medically necessary emergency care in an foreign county.

Plan F Benefit Plan: (not available to individuals newly eligible for Medicare on or after 1.1.20)

Standardized Medicare supplement benefit Plan F shall include the following in addition to the core benefits listed above:

- 100% of the Medicare Part A deductible,
- Skilled nursing facility care,
- 100% of the Medicare Part B deductible,
- 100% of the Medicare Part B excess charges and
- Medically necessary emergency care in a foreign country.

Plan F - High Deductible: (not available to individuals newly eligible for Medicare on or after 1.1.20)

Standardized Medicare supplement benefit Plan F High Deductible shall include the following in addition to the core benefits listed above:

- 100% of covered expenses following the payment of the annual high deductible Plan F deductible
- 100% of the Medicare Part A deductible,
- Skilled nursing facility care,
- 100% of the Medicare Part B deductible,
- 100% of the Medicare Part B excess charges, and
- Medically necessary emergency care in a foreign county. (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 basis of the deductible shall be \$1,500 and shall be adjusted annually from 1999 by the HHS Secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year and rounded to the nearest multiple of \$10).

Benefit Plan G: - Standardized Medicare supplement benefit Plan G shall include the following in addition to the core benefits listed above:

- 100% of the Medicare Part A deductible,

- Skilled nursing facility care,
- 100% of the Medicare Part B excess charges, and
- Medically necessary emergency care in a foreign county.

Plan G - High Deductible: Standardized Medicare supplement benefit Plan G High Deductible shall include the following in addition to the core benefits listed above:

- 100% of covered expenses following the payment of the annual high deductible Plan G deductible
- 100% of the Medicare Part A deductible,
- Skilled nursing facility care,
- 100% of the Medicare Part B excess charges, and
- Medically necessary emergency care in a foreign county. (The annual high deductible Plan G deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan G policy, and shall be in addition to any other specific benefit deductibles. The basis of the deductible shall be \$2,300 and shall be adjusted annually from 2019 by the HHS Secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10).

Benefit Plan K: Standardized Medicare supplement benefit Plan K shall include the following in addition to the core benefits listed above:

- Part A hospital coinsurance, day 61 through day 90.* Coverage of 100% of the Part A hospital coinsurance amount for each day used from day 61 through day 90 in any Medicare benefit period.
- Part A hospital coinsurance, day 91 through day 150.* Coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from day 91 through day 150 in any Medicare benefit period.
- Part A hospitalization after 150 days.* On exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system 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.
- Medicare Part A deductible,* Coverage for 50% of Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met.
- Skilled nursing facility care.* Coverage for 50% of the coinsurance amount for each day used from day 21 through the day 100 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.
- Hospice care.* Coverage for 50% of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met.
- Blood.* Coverage for 50% under Medicare Part A or B, of the reasonable cost of the first three 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.
- Part B cost sharing.* Except for Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible, coverage for 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.

- Part B preventive services.* Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible.
- Cost sharing after out-of-pocket limits.* Coverage of 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 \$5,560 in 2019, indexed each year by the appropriate inflation adjustment specified by the HHS Secretary.

Benefit Plan L: Standardized Medicare supplement benefit Plan L shall include the following in addition to the core benefits listed above:

- Part A hospital coinsurance, day 61 through day 90.* Coverage of 100% of the Part A hospital coinsurance amount for each day used from day 61 through day 90 in any Medicare benefit period.
- Part A hospital coinsurance, day 91 through day 150.* Coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from day 91 through day 150 in any Medicare benefit period.
- Part A hospitalization after 150 days.* On exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system 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.
- Part B preventive services.* Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible.
- Medicare Part A deductible.* Coverage for 75% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met.
- Skilled nursing facility care.* Coverage for 75% of the coinsurance amount for each day used from day 21 through the day 100 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.
- Hospice care.* Coverage for 75% of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met.
- Blood.* Coverage for 75% under Medicare Part A or B, of the reasonable cost of the first three 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.
- Part B cost sharing.* Except for Coverage of 100% of the cost sharing for Medicare Part B preventive services, after the policyholder pays the Part B deductible coverage for 75% 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.
- Cost sharing after out-of-pocket limits.* Coverage of 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 \$2,780 in 2019, indexed each year by the appropriate inflation adjustment specified by the HHS Secretary.

Benefit Plan M: Standardized Medicare supplement benefit Plan M shall include the following in addition to the core benefits listed above:

- 50% of the Medicare Part A deductible.

- Skilled nursing facility care and
- Medically necessary emergency care in a foreign county.

Benefit Plan N: Standardized Medicare supplement benefit Plan N shall include the following in addition to the core benefits listed above:

- 100% of the Medicare Part A deductible,
- Skilled nursing facility care and
- Medically necessary emergency care in a foreign country with co-payments in the following amounts:
 - The lesser of \$20 or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit, including visits to medical specialists.
 - The lesser of \$50 or the Medicare Part B coinsurance or co-payment for each covered emergency room visit, except that the 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.

SECTION III: APPLICATION FORM REQUIREMENTS

This section is an overview only; please review each cited statute for specific information

The Department cannot accept specimen or draft forms. All forms must be in final print version intended to be issued by the Company.

Open Enrollment [31 Pa. Code §89.778] – The Company must offer each policy currently available from the insurer to applicants who qualify without regard to age. Eligibility criteria may be captured in the application or a supplemental application.

Guaranteed Issue [31 Pa. Code § 89.790] – “With respect to eligible persons, an issuer may not: (i) 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. (ii) Discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care or medical condition. (iii) Impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.” The Company has the option to capture Guaranteed Issued eligibility requirements in the application or a supplemental application.

Fraud Language in the Application [Title 18 Crimes and Offenses §4117(k) (1)] - Applications for insurance must contain the required Pennsylvania fraud language.

Medical Questions [31 Pa. Code § 89.12(d) and 31 Pa. Code § 89.72] - Applications shall contain clear and direct questions by the insurer permitting answers by the applicant only in the form of direct statements of known facts. Applications may not contain questions or representations based on indefinite or ambiguous terms. Opinion-type questions regarding the past or present health of the applicant should provide that the applicant is to answer to the best of his knowledge and belief.

☐ **Fraternal Benefit Society** [31 Pa. Code § 89.102(d)] - Specific guidelines for applications including the words "A Fraternal Benefit Society" shall appear in conspicuous type on the insurance application.

☐ **Application Requirements** [31 Pa. Code § 89.784)] - Filing includes requirements for application form, replacement coverage and notice of replacement. The Statements captured in 31 Pa. Code Section 89.784(1) must appear on the application. 31 Pa. Code Section 89.784(2) requires questions to elicit whether as of the date of application, the applicant currently has Medicare Supplement, Medicare Advantage, Medicaid Coverage or another health insurance policy/certificate presently 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 producer containing these questions and statements may be used.

☐ **Genetic Information Nondiscrimination Act** [31 Pa. Code § 89.791] - Prohibition against the use of genetic information and requests for genetic testing. (c) An issuer of a Medicare supplement policy may not: (1) Use an individual's genetic information to deny or condition the issuance or effectiveness of a policy or certificate to that individual, including the imposition of an exclusion of benefits based on a pre-existing condition. (2) Use an individual's genetic information to discriminate in the pricing of the policy, including the adjustment of premium rates. (3) Request or require an individual or an individual's family member to undergo a genetic test. Please see regulation for details.

☐ **Guide to Health Insurance for People with Medicare** [31 Pa. Code § 89.783(a) (6)] – Regulation requires this disclosure to be made. The application form contains an area for the applicant to acknowledge the receipt of this disclosure. A link to the CMS Website that contains the Guide is provided as a courtesy to the Company.
[\[https://www.medicare.gov/Pubs/pdf/02110-Medicare-Medigap-guide.pdf\]](https://www.medicare.gov/Pubs/pdf/02110-Medicare-Medigap-guide.pdf)

SECTION IV: DISCLOSURE FORM REQUIREMENTS

☐ **Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage** [31 Pa. Code §89.784(4)] - Filing includes requirements for notice of replacement. If a sale involves replacement of Medicare supplement coverage, an issuer, other than a direct response issuer, or its agent shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent shall be provided to the applicant and an additional signed copy shall be retained by the issuer, except where the coverage is sold without an agent. 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. The Notice Regarding Replacement is published on the Department website.
[\[https://www.insurance.pa.gov/Companies/ProductAndRateRequire/Documents/Notice_Regarding_Replacement_Disclosure_Requirement.pdf\]](https://www.insurance.pa.gov/Companies/ProductAndRateRequire/Documents/Notice_Regarding_Replacement_Disclosure_Requirement.pdf). It is the issuers responsibility to

comply with this regulation – you must have forms approved by the Department for this purpose.

□ **Outline of Coverage** [31 Pa. Code §89.783(D)] – The Medicare supplement insurance form filing includes an outline of coverage. The outline of coverage consists of four parts: the cover page, rate pages, disclosure page and charts. The outline should have a unique form number from any other form submitted for approval and the number should be consistent on all four parts. The outline of coverage must be presented in 12 point type. The premium and mode shall be stated for all plans that are offered to the prospective applicant on the rate pages. All possible premiums for the prospective applicant shall be illustrated. The premium should be bracketed to denote variability to avoid the necessity for annual re-filing of the form. The outline of coverage is published on the Department website.

[<https://www.insurance.pa.gov/Companies/ProductAndRateRequire/Documents/OCov%20MS%20after%2001.01.2020.pdf>]

□ **Notice of Benefit Modification and Premium Adjustment Form** (aka Notice of Change Form) [31 Pa. Code § 89.783(b)] - Such form must be provided for each Medicare Supplement Policy Form. A specimen has been published on the Department website.

[https://www.insurance.pa.gov/Companies/ProductAndRateRequire/Documents/Plan_G_Specimen_Notice_2020.pdf]

□ **Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries That Duplicate Medicare** [31 Pa. Code Section 89.783(f)] – Regulation requires disclosure to be made for Health Insurance Policies sold to Medicare Beneficiaries that duplicate Medicare. The link is provided as a courtesy to the Company. The Disclosure Requirements for Accident and Sickness Policies are published on the Department website.

[https://www.insurance.pa.gov/Companies/ProductAndRateRequire/Documents/Guide_to_Health_Insurance_for_People_with_Medicare_02.01.2019.pdf]

SECTION V: ELECTRONIC TRANSACTIONS

Filings Submitted for Electronic Transactions: The rights of consumers under existing laws need to be protected and preserved. The insurer must comply with the Pennsylvania Electronic Transactions Act [73 P.S. §§ 2260.101 et seq.]. The Company must also certify their compliance with the Electronic Transactions Act requirements.

SECTION VI: MEDICARE “SELECT” ADDITIONAL REQUIREMENTS

Medicare Supplement “Select” Policies and Certificates contains restricted network provisions. The Commissioner may authorize an issuer to offer a Medicare Select policy or certificate, under this section, and section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 (42 U.S.C.A. § 1395b-2) if the Commissioner finds that the issuer has satisfied the requirements of 31 § 89.777a.

A Medicare Select issuer may not issue a Medicare Select policy or certificate in this State until its plan of operation has been approved by the Commissioner.

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.

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 6 months. 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.

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

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:

Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers.

A demonstration that 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 the usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

The number of network providers in the service area is sufficient, with respect to current and expected policyholders, to deliver adequately all services that are subject to a restricted network provision; make appropriate referrals;

There are written agreements with network providers describing both parties' specific responsibilities;

Emergency care is available 24 hours per day and 7 days per week

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 subparagraph does not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

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

- A description of the grievance procedure to be utilized.
- A description of the complaint procedure to be utilized.
- A description of the quality assurance program, including the following: the formal organizational structure, the written criteria for selection, retention and removal of network providers, the procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.
- A list and description, by specialty, of the network providers.
- Copies of the written information proposed to be used by the issuer to comply with the Medicare Select issuer requirement to make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant.
- Other information pertinent to the plan of operation requested by the Commissioner.

This section applies to Medicare Select policies as defined in 31 Pa. Code § 89.777a. A Medicare Select policy is a Medicare supplement policy that contains restricted network provisions.

- A restricted network provision conditions the payment of benefits, in whole or in part, on the use of network providers.
- Make sure all attachments and/or exhibits are clearly marked using accurate form names/captions/headers (E.g. Plan of Operation describes an attachment for Network Agreement but the attached form has a title Schedule C).

Below are additional requirements pertaining to a Medicare Select Forms filing in Pennsylvania.

- Plan of Operation** – Must provide evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:
 - 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 the usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.
 - The number of network providers in the service area is sufficient, with respect to current and expected policyholders, to either:
 - Deliver adequately all services that are subject to a restricted network provision.
 - Make appropriate referrals.
 - There are written agreements with network providers describing both parties' specific responsibilities.
 - Emergency care is available 24 hours per day and 7 days per week.
 - 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 subparagraph does not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

- A statement or map providing a clear description of the service area.
- A description of the grievance procedure to be utilized.
- A description of the complaint procedure to be utilized.
- A description of the quality assurance program, including the following:
 - The formal organizational structure.
 - The written criteria for selection, retention and removal of network providers
 - The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.
 - A list and description, by specialty, of the network providers.
 - Copies of the written information proposed to be used by the issuer to comply with subsection of 31 Pa. Code § 89.777a(j).

A Medicare Select Policy may not restrict payment for covered services provided by non-network providers if the following apply:

- The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition.
- It is not reasonable to obtain services through a network provider.

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.

Full and Fair Disclosure - A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy to each applicant. This disclosure shall include at least the following:

- An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy with Medicare supplement policies or certificates offered by the issuer.
- Other Medicare Select policies.
- A description, including the 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 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.
- A description of coverage for emergency and urgently needed care and other 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 rights to purchase another Medicare supplement policy or certificate otherwise offered by the issuer.

A description of the Medicare Select issuer's quality assurance program and grievance procedure.

Applicant Acknowledgement - 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 under 31 Pa. Code § 89.777a(j) and that the applicant understands the restrictions of the Medicare Select policy or certificate.

Complaint and Grievance Procedures - 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.

The complaint and grievance procedure shall be described in the policy and certificates and in the outline of coverage.

At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a complaint or grievance may be registered with the issuer.

Complaints and grievances shall be considered within 45 days. If a benefit determination by Medicare is necessary, the 45-day review period may not begin until after the Medicare determination has been made. The complaint or grievance shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

If a complaint or grievance is found to be valid, corrective action shall be taken within 45 days.

The concerned parties shall be notified about the results of a complaint or grievance within 45 days of the decision.

The issuer shall report by March 31 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 the grievances.

At the time of initial purchase, a Medicare Select issuer shall make available to each for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

For purposes of this section the following apply:

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 available without requiring evidence of insurability after the Medicare Select policy has been in force for 6 months.

For the purposes of this subsection, a Medicare supplement policy will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare *Select* policy 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.

☐ MEDICARE *SELECT* POLICIES SHALL PROVIDE FOR CONTINUATION OF COVERAGE IN THE EVENT THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES SECRETARY DETERMINES THAT MEDICARE *SELECT* POLICIES ISSUED UNDER THIS SECTION SHOULD BE DISCONTINUED DUE TO EITHER THE FAILURE OF THE MEDICARE SELECT PROGRAM TO BE REAUTHORIZED UNDER LAW OR ITS SUBSTANTIAL AMENDMENT.

☐ Each Medicare Select issuer shall make available to each individual insured under a Medicare *Select* policy the opportunity to purchase any Medicare supplement policy 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 available without requiring evidence of insurability.

☐ For the purposes of this subsection, a Medicare supplement policy will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare *Select* policy 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.

☐ **Changes to Plan of Operation and List of Network Provider Filing Requirements**
- A Medicare *Select* issuer shall file (1) proposed changes to the plan of operation, except for changes to the list of network providers and (2) An updated list of network providers with the Commissioner at least quarterly, if changes occur.

Actuarial Rate Filing:

Filing of rating schedule and supporting documentation [31 Pa. Code § 89.781]. - An issuer may 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.

It is necessary to attach all proposed Rates and Rating Factor tables necessary to calculate an insured’s final rate under the “Rate/Rule Schedule” Tab of your SERFF filing. All other actuarial documentation must be included under the “Supporting Documentation” tab. Note: It is necessary to include all factors necessary to calculate a final rate. Excel workbooks should be provided in both Excel and PDF format.

Loss ratio standards [31 Pa. Code § 89.780] - A Medicare Supplement policy form may 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 return to policyholders in the form of aggregate benefits, a percentage of the aggregate amount of premiums earned. The amount returned as benefits shall be equal to: (i) At least 75% of the aggregate amount of premiums earned in the case of group policies, and (ii) At least 65% of the aggregate amount of premiums earned in the case of individual policies.

[31 Pa. Code § 89.780 (c)(1)(i)] – An issuer shall make premium adjustments as necessary to produce an expected loss ratio under the policy that will conform with minimum loss ratio standards for Medicare supplement policies, and that will result in an expected loss ratio at least as great as that originally anticipated by the issuer for that policy. A premium adjustment which would modify the loss ratio experience under the policy other than the adjustments provided in this section may not be made with respect to a policy at any time other than upon its renewal or anniversary date.

It is necessary to provide at least a 10-year durational premium and claims projection for each form to demonstrate the present value anticipated lifetime loss ratio. This anticipated lifetime loss ratio will be the minimum standard for all future rate adjustment and compliance filings for this form.

Open enrollment [31 Pa. Code § 89.778] – An issuer may not discriminate in the pricing of a policy 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 that is submitted prior to or during the 6-month period beginning with the first day of the first month in which an individual enrolled for benefits under Medicare Part B, or was informed of retroactive eligibility to enroll. Each Medicare supplement policy currently available from an issuer shall be made available to applicants who qualify under this section without regard to age.

Permitted compensation arrangements [31 Pa. Code § 89.782] - a) An issuer or other entity may provide a commission or other compensation to a producer or other representative for the sale of a Medicare supplement policy or certificate only if the 1st-year commission or other 1st-year compensation is no more than 200% of the commission or other compensation paid for selling or servicing the policy or certificate in the 2nd year or period. (b) The commission or other compensation provided in subsequent (renewal) years shall be the same as that provided in the 2nd year or period and shall be provided for no fewer than 5 renewal years. (c) An issuer or other entity may not provide compensation to its producers or its other representatives and a producer may not 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 bonuses, gifts, prizes, awards and finder's fees.