Medicare Supplement Checklist

Updated August 2022

TO BE COMPLETED BY COMPANY

Company Name:

SERFF TOI:

SERFF SUB TOI:

SERFF Tracking #:

Plan Type (check one)	
☐	Standard Medicare Supplement
☐	Medicare Select

ELECTRONIC REFERENCES - FEDERAL
Code of Federal Regulations
United States Code
U.S. Preventive Services Task Force

ELECTRONIC REFERENCES - ILLINOIS
Illinois Insurance Code
Administrative Rules
Illinois Company Bulletins

Checklist Directions

- The checklist must be completed to indicate where in the filing the General Filing requirements appear, must acknowledge each General Form Requirement and must indicate where, in the policy form, each required provision appears (e.g. form number, page number and section number).
- For requirements marked as "Affirmed," companies are to acknowledge, by checking the appropriate box: 1) their compliance with prohibited language; or 2) their understanding of the informational nature of the requirement.
- This document is to be downloaded and submitted with this filing in SERFF. Alteration of this document will result in rejection of the filing.

Index Directions

Part 1 must be completed for all policies.
Part 2 must also be completed for all Medicare Select policies.

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Section B	REQUIRED MEDICARE SUPPLEMENT PROVISIONS
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PART 1 - ALL POLICIES

SECTION A - GENERAL FILING REQUIREMENTS

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
1.A.1	Review Requirements Checklist	Review Requirements Checklists	Each filing must include a completed Review Requirements Checklist that must contain a completed "Location of Standard in Filing" column for each required element of the filing. Please indicate the proper page # and form # for each entry.	
1.A.2		50 IAC 916.40(b)	Each filing shall be submitted directly through SERFF and shall include a description of the submission in the general filing description or a letter of submission under supporting documents in the filing.	
1.A.3	Outline of Coverage	215 ILCS 5/363a(6)(b) 50 IAC 2008.90(f) 50 IAC 2008.APPENDIX W	The outline of coverage shall consist of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer.	☐
1.A.4	Form Filing Requirements	50 IAC 916.40(b) 50 IAC 2008.81(a)	Each company shall file with the Director for approval each new policy form in a searchable text PDF before it is issued or delivered in this State.	☐
1.A.5	Filings by Plan Type	215 ILCS 5/143(1)	The Department requires separate filings per Medicare Supplement Plan (A,C,F,G, etc.)	☐

1.A.6	Rates	50 IAC 2008.80(a)(2) 50 IAC 2008.81(c) 50 IAC 916.40(e)(1) 50 IAC 2008.80(c) 215 ILCS 5/363(8) (NEW)	An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed through SERFF and approved by the Director. Annual rate filings are required. During the age 75 and under open enrollment period, rates may not discriminate in the pricing of coverage, because of health status, claims experience, receipt of health care, or a medical condition of the individual.	SERFF Tracking#
1.A.7	Certificate of Compliance	50 IAC 916.40(a)	Each company doing business in the State of Illinois shall submit with each filing a Certificate of Compliance.	☐
1.A.8	Use of SSN on ID Cards	815 ILCS 505/2QQ	A person or entity may not print an individual's social security number on an insurance card. A person or entity that provides an insurance card must print on the card an identification number unique to the holder of the card in the format prescribed by Section 15 of the Uniform Prescription Drug Information Card Act.	☐
1.A.9	Policy Form Variations	215 ILCS 5/143(1)	Issuers are limited to up to five policy forms with variations based on inclusion of innovative benefits, marketing methods, underwriting method and eligibility for Medicare (aged versus disabled). The forms represent "reporting classes," which are the level at which experience will be presented to the State for experience rating purposes.	☐
SECTION B - REQUIRED MEDICARE SUPPLEMENT PROVISIONS				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
1.B.1	Preexisting Conditions	50 IAC 2008.64 (a)(1) 215 ILCS 5/363(8) (NEW)	A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage because it involved a preexisting condition. Members may not be denied coverage during the age 75 and under open enrollment period adopted effective 1/1/2022 for pre-existing conditions or health status.	
1.B.2	Medicare Cost Sharing	50 IAC 2008.64 (a)(3)	A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.	
1.B.3	Guaranteed Renewability	50 IAC 2008.64 (a)(5)	Each Medicare supplement policy shall be guaranteed renewable as outlined in the Illinois Administrative Code.	
1.B.4	Age 75 Open Enrollment (NEW)	215 ILCS 5/363(8) (NEW)	If an individual is at least 65 years of age but no more than 75 years of age and has an existing Medicare supplement policy, the individual is entitled to an annual open enrollment period lasting 45 days, commencing with the individual's birthday, and the individual may purchase any Medicare supplement policy with the same issuer that offers benefits equal to or lesser than those provided by the previous coverage. Notice of this annual open enrollment period shall occur at the time the application is made for the policy or certificate for eligible Medicare supplement policyholders	
1.B.5	Notification of New Enrollment	215 ILCS 5/363(8) (NEW)	Please affirm by checking the box to the right that notification is provided at the time application is made advising members under the age of 75 of their right to choose a different Medicare supplement plan with your company, if applicable. If you do not have available plans for members to select, please provide that information in your cover letter in the SERFF filing and disregard this section of the checklist.	☐
1.B.6	Riders/Endorsements	50 IAC 2008.90(a)(2)	The insured must agree in writing to policy or endorsements that reduce or eliminate benefits after coverage is in force or at the time of reinstatement with limited exceptions as outlined in the 50 IAC 2008.90(a)(2).	
1.B.7	Usual and Customary	50 IAC 2008.90(a)(3)	Policies may not provide benefit payments based on standards described as "usual and customary", "reasonable and customary" or terms similar in nature.	
1.B.8	Pre-existing Limitations	50 IAC 2008.90(a)(4) 215 ILCS 5/363(5)	Policies containing pre-existing condition provisions must be placed in a separate paragraph and be labeled as "Preexisting Condition Limitations". A Medicare Supplement policy or certificate may not deny a claim for losses incurred more than 6 months from the effective date of coverage.	
1.B.9	Free Look	50 IAC 2008.90(a)(5) 215 ILCS 5/363(4)	Policies must contain a 30-day free look provision.	
1.B.10	Guide to Health Insurance for People with Medicare	50 IAC 2008.90(a)(6) 215 ILCS 5/363a(6)(c)	Issuers of Medicare Supplement policies that provide benefits on an expense incurred or indemnity basis must provide applicants with a Guide to Health Insurance for People with Medicare that has been approved by the Director.	
1.B.11	Identification Cards	50 IAC 2008.90(b)	Identification cards provided to the policyholder(s) must reflect the name of the issuer rather than a corporate name and must also identify which plan of coverage is being provided to the policyholder.	
1.B.12	Policy Checklist	50 IAC 2008.90(c) 50 IAC 2008.Appendix A 215 ILCS 5/363a(3)(f)	A policy checklist is required and must conform with Appendix A.	
1.B.13	Outline of Coverage	50 IAC 2008.90(f) 50 IAC 2008 Appendix B 215 ILCS 5/363a(6)(a)(b)	An outline of coverage is required. It must indicate all the plans and corresponding premium rates the insurer has available in Illinois. The cover letter must disclose the previously approved policy(s) form numbers and filing numbers as well as approval date for the previously approved filings to which the new rate filing applies.	
1.B.14	Advertising Filing Requirements	50 IAC 2008.90(h)	An issuer of Medicare supplement insurance or benefits in this State shall provide a copy of any Medicare supplement advertisement intended for use in this State to the Director for review.	

1.B.15	Application Forms	50 IAC 2008.100(a)	Application forms must include a replacement questions as specifically provided by 50 IAC 2008.100(a)(1) and (2).	
1.B.16	Replacement Notice	50 IAC 2008.100(d) & (e) 50 IAC 2008.Appendix R	Upon determining that a sale will involve replacement of Medicare supplement, an issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of accident and sickness coverage in the form prescribed in Appendix R	
1.B.17	Genetic Testing	50 IAC 2008.107	Insurers shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) on the basis of the genetic information with respect to that individual, nor shall they discriminate in the pricing of the certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to that individual.	
SECTION C - STANDARDIZED MEDICARE SUPPLEMENT PLANS (A-L)				
PLEASE NOTE: APPENDICES AA THROUGH JJ ARE FOUND WITHIN APPENDIX W				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
1.C.1	Core Benefits	50 IAC 2008.Appendix W	Appendix W shows the benefits included in each of the standard Medicare supplement plans.	
1.C.2	Plan A	50 IAC 2008.67(b) 50 IAC 2008.67(c) 50 IAC 2008.Appendix W 50 IAC 2008.Appendix AA	Core Benefits plus Plan A Requirements in Appendix AA. • The core benefits.	
1.C.3	Plan B	50 IAC 2008.67(b) 50 IAC 2008.67(c) 50 IAC 2008.Appendix W 50 IAC 2008.Appendix BB	Core Benefits plus Plan B Requirements in Appendix BB. • The core benefits; and • 100% of the Medicare Part A deductible.	
1.C.4	Plan C	50 IAC 2008.67(b)(c) 50 IAC 2008.Appendix W 50 IAC 2008.Appendix CC	Core Benefits plus Plan C requirements in Appendix CC -- The core benefits -- 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 C cannot be sold to newly eligible Medicare recipients effective on or after 1/1/2020	
1.C.5	Plan D	50 IAC 2008.67(b) 50 IAC 2008.67(c) 50 IAC 2008.Appendix W 50 IAC 2008.Appendix DD	Core Benefits plus Plan D Requirements in Appendix DD. • The core benefits; • 100% of the Medicare Part A deductible; • Skilled nursing facility care; and • Medically necessary emergency care in an foreign country.	
1.C.6	Plan F High Deductible Plan F	50 IAC 2008.67(b) 50 IAC 2008.67(c) 50 IAC 2008.Appendix W 50 IAC 2008.Appendix EE	Core Benefits plus Plan F Requirements in Appendix EE. -- The core benefits; -- 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. Standardized Medicare supplement Plan G With High Deductible shall include 100% of covered expenses following the payment of the annual deductible.	
1.C.7	Plan G Plan G High Ded	50 IAC 2008.67(b) 50 IAC 2008.67(c) 50 IAC 2008.Appendix W 50 IAC 2008.Appendix FF	Core Benefits plus Plan G Requirements in Appendix FF. • The core benefits; • 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 country. Standardized Medicare supplement Plan G With High Deductible shall include 100% of covered expenses following the payment of the annual deductible.	

1.C.8	Plan K	50 IAC 2008.67(b) 50 IAC 2008.67(c) 50 IAC 2008.Appendix W 50 IAC 2008.Appendix GG	Core Benefits plus Plan K Requirements in Appendix GG. • Part A Hospital Coinsurance 61st through 90th days. • Part A Hospital Coinsurance, 91st through 150th days. • Part A Hospitalization After 150 Days. • 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met. • Coverage for 50% of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met. • Coverage for 50% of cost sharing for all Part A Medicare eligible expenses and hospice care until the out-of-pocket limitation is met. • Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood until the out-of-pocket limitation is met. • 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. • Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible. • 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 $4000 in 2006.	
1.C.9	Plan L	50 IAC 2008.67(b) 50 IAC 2008.67(c) 50 IAC 2008.Appendix W 50 IAC 2008.Appendix HH	Core Benefits plus Plan L Requirements in Appendix HH. • Part A Hospital Coinsurance 61st through 90th days. • Part A Hospital Coinsurance, 91st through 150th days. • Part A Hospitalization After 150 Days. • Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible. • 75% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out- of-pocket limitation is met. • Coverage for 75% of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met. • Coverage for 75% of cost sharing for all Part A Medicare eligible expenses and hospice care until the out-of-pocket limitation is met. • Coverage for 75%, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood until the out-of-pocket limitation is met. • 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. • 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 $2000 in 2006.	
1.C.10	Plan M	50 IAC 2008.67(b) 50 IAC 2008.67(c) 50 IAC 2008.Appendix W 50 IAC 2008.Appendix II	Core Benefits plus Plan M Requirements in Appendix II. • The basic (core) benefit; • 50% of the Medicare Part A deductible; • Skilled nursing facility care; and • Medically necessary emergency care in a foreign country.	
1.C.11	Plan N	50 IAC 2008.67(b) 50 IAC 2008.67(c) 50 IAC 2008.Appendix W 50 IAC 2008.Appendix JJ	Core Benefits plus Plan N Requirements in Appendix JJ. • The basic (core) benefit; • 100% of the Medicare Part A deductible; • Skilled nursing facility care; • Medically necessary emergency care in a foreign country; • Copayment of the lesser of $20 or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and • Copayment of the lesser of $50 or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.	

Part 2 - MEDICARE SELECT POLICIES AND CERTIFICATES

SECTION A - GENERAL FILING GUIDELINES

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
2.A.1	Definition of Medicare Select Policy	50 IAC 2008.73(b)(4)	"Medicare Select Policy" or "Medicare Select Certificate" means respectively a Medicare supplement policy or certificate that contains restricted network provisions.	
2.A.2	Out-of-Network Reimbursement	50 IAC 2008.73(g) and (h)	A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if: The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or condition; and It is not reasonable to obtain such services through a network provider; or covered services are not available through network providers.	
2.A.3	Outline of Coverage	50 IAC 2008.73(i)(1)	A Medicare Select issuer shall provide an outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with: • Other Medicare supplement policies or certificates offered by the issuer; and • Other Medicare Select policies or certificates.	
2.A.4	Network Disclosure	50 IAC 2008.73(i)(2) through (5)	A Medicare Select issuer shall provide: • 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 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; and • A description of limitations on referrals to restricted network providers and to other providers.	
2.A.5	Grievance Procedure	50 IAC 2008.73(k)(2)	At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.	
2.A.6	Continuation of Coverage	50 IAC 2008.73(n)	Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this Section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.	

IMPORTANT NOTICE: This Checklist does not include all of the requirements of Illinois laws, regulations or bulletins. Companies are responsible for reviewing Illinois laws, regulations and bulletins to ensure that forms are fully compliant before filing the forms.

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