

Department of Consumer & Business Services
Oregon Division of Financial Regulation - 5

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**Standard Provisions for Individual and Group Medicare Supplement
Standard or Select**

This checklist must be submitted with your filing, in compliance with OAR 836-010-0011(2). This list includes the national standards, relevant statutes, rules, and other documented positions to enforce ORS 731.016. The standards are summaries and a review of the entire statute or rule may be necessary. Complete each item to confirm that diligent consideration has been given to each and is certified by the signature on the certificate of compliance form. "Not applicable" can be used only if the item does not apply to the coverage being filed. Any line left blank will cause this filing to be considered incomplete. Not including the required information or the policy provisions may result in disapproval of the filing. *(If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.)*

INSURER NAME: _____

DATE: _____

Please indicate the type of file you are submitting:

- TOI (type of insurance):**
- MS04I Individual Medicare supplement - Medicare select
 - MS05I Individual Medicare supplement - Standard plans
 - MS04G Group Medicare supplement - Medicare select
 - MS05G Group Medicare supplement - Standard plans

- Sub TOI:**
- | | |
|--|--|
| <input type="checkbox"/> MS04I.001 to .014 All plans | <input type="checkbox"/> Filing specific plans (<i>identify</i>) _____ |
| <input type="checkbox"/> MS05I.001 to .014 All plans | <input type="checkbox"/> Filing specific plans (<i>identify</i>) _____ |
| <input type="checkbox"/> MS04G.001 to .014 All plans | <input type="checkbox"/> Filing specific plans (<i>identify</i>) _____ |
| <input type="checkbox"/> MS05G.001 to .014 All plans | <input type="checkbox"/> Filing specific plans (<i>identify</i>) _____ |

For a group policy that is to be issued to a trust, association, or discretionary group that has not been previously approved, the filing must include a complete transmittal and Product Standards form, 440-2441, found on our website at:
<http://dfr.oregon.gov/rates-forms/Documents/2442.pdf>.

| Review Requirements | Reference | Description of Review Standards Requirements | Check answer | |
|---|--|---|---|---|
| GENERAL REQUIREMENTS (FOR ALL FILINGS) | | | | |
| Submission package requirements | OAR 836-010-0011 As required on SERFF or our Web site | <p>Required forms are located on SERFF or on our website: http://dfr.oregon.gov/rates-forms/health/Pages/health.aspx. In order for your filing to be accepted, it must include the following documents:</p> <ol style="list-style-type: none"> 1. NAIC transmittal form. 2. Filing description on transmittal form (cover letter). 3. Third party filer's letter of authorization. 4. Certificate of compliance form signed by authorized person. 5. Readability certification. 6. Product standards for forms (this document). Every line item must be completed on the product standards. 7. Actuarial memorandum with an overview of the contents of the filing and the reasons and procedures used to derive the rates. 8. Forms filed for approval. (If filing revised forms, include a highlighted copy of the revised form to identify the modification, revision, or replacement language.) 9. For mailed filings, submit two sets of the complete filing and one self-addressed stamped envelope, large enough for the Division of Financial Regulation to return the approved forms. 10. All relevant components listed on our web-site for this product must be completed and submitted with this filing. The filing will be disapproved if all the required components are not attached in accordance to the directions outlined on our web-site. 11. If you are submitting your filing electronically, each form item must be bookmarked. | Yes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | N/A <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| | Additional submission requirements for Medicare | <p>The filing includes:</p> <ol style="list-style-type: none"> 1. Related advertising material to be used with new forms. ORS 742.009, ORS 743.687, and OAR 836-052-0170. 2. Outline of coverage. ORS 743.685. For Medicare standard, OAR 836-052-0160, see Exhibit- Appendix C; For Medicare Select, see OAR 836-052-0139 and OAR 836-052-0139(12)(a). 3. Application for replacement coverage and notice of replacement form. OAR 836-052-0165(1)-(6), OAR 836-052-0165, and OAR 836-052-0142. 4. For Medicare select filings, a plan of operation. OAR 836-052-0139(5) and (6). 5. For Medicare select filings, a current list of network providers. OAR 836-052-0139(7)(b). | Yes <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | N/A <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |

| Review Requirements | Reference | Description of Review Standards Requirements | Check answer or enter page & paragraph |
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| Review requested | ORS 742.003(1), ORS 742.005(1), OAR 836-010-0011(4) | The following are submitted in this filing for review: 1. New policy and/or certificate. Includes related advertising material (ORS 742.009, ORS 743.687, and OAR 836-052-0170). 2. Amendment to an approved form. 3. Addition of supplemental options to previously approved plans. | Yes N/A <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Filing description on transmittal form | | The filing description (cover letter) includes the following: 1. Summary of the differences between prior approved like forms and the new forms. 2. The differences between in-network and out-of-network, if applicable. | Yes N/A <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Advertising Material | ORS 742.009, ORS 743.687, OAR 836-052-0170 | Related advertising material to be used with new policy form filings is included | Yes N/A <input type="checkbox"/> <input type="checkbox"/> |
| Redline version | OAR 836-010-0011(4) | Forms filed for approval. If filing revised forms, include a highlighted or redline copy of the revised form to identify the modification, revision, or replacement language. The cover letter must identify any exceptions the insurer is using to modify the required design. | Yes N/A <input type="checkbox"/> <input type="checkbox"/> |

(Skip to Requirements for Rates if only filing a rate change.)

| FORMS | | | |
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| Associations/trusts/discretionary groups | ORS 731.486, ORS 743.522, ORS 743.524, Form 440-2441 | Transmittal and standards for qualifying an association, trust, or discretionary group (use Form 440-2441). | Yes N/A <input type="checkbox"/> <input type="checkbox"/> |
| Assumption certificates | Form 440-3637 | File under checklist of standards for <u>Changes to Business Operations that Require a Filing</u> , Form 440-3637. | Yes N/A <input type="checkbox"/> <input type="checkbox"/> |
| Applicability | OAR 836-052-0136(7) | If the policy or certificate contains new or innovative benefits, in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards, the new or innovative benefits may include benefits that are appropriate to Medicare Supplement insurance. New or innovative benefits are those that are not otherwise available, are cost-effective, and offered in a manner consistent with the goal of simplification of Medicare supplement policies. | |
| Application | Form 440-2442H | Product Standard, Form 440-2442H, must be included in the filing if an application form is submitted. | Yes N/A <input type="checkbox"/> <input type="checkbox"/> |
| | OAR 836-052-0165 | The statements and questions contained on the application comply with OAR 836-052-0165. | Yes N/A <input type="checkbox"/> <input type="checkbox"/> |

| Review Requirements | Reference | Description of Review Standards Requirements | Check answer | |
|-------------------------|-----------------------------------|---|---------------------------------|---------------------------------|
| Cover page | National standards | 1. The full corporate name of the insuring company appears prominently on the first page of the policy. | Yes <input type="checkbox"/> | N/A <input type="checkbox"/> |
| | | 2. A marketing name or insurer's logo, if used on the policy, does not mislead as to the identity of the insuring company. | <input type="checkbox"/> | <input type="checkbox"/> |
| | | 3. The insuring company address, consisting of at least a city and state, appears on the first page of the policy. | <input type="checkbox"/> | <input type="checkbox"/> |
| | | 4. The signature of at least one company officer appears on the first page of the policy. | <input type="checkbox"/> | <input type="checkbox"/> |
| | | 5. The individual certificate includes a right-to-examine provision that appears on the cover page of the certificate. (Not applicable to riders, endorsements, and addendums.) ORS 743.686 and OAR 836-052-0160(1)(e) | <input type="checkbox"/> | <input type="checkbox"/> |
| | | 6. A form-identification number appears in the lower left-hand corner of the forms. (The form number is adequate to distinguish the form from all others used by the insurer). | <input type="checkbox"/> | <input type="checkbox"/> |
| | | 7. The policy contains a brief caption that appears prominently on the cover page and describes the type of coverage. (a) A caption of the type of coverage provided identified by the letter of the standardized plan. (For example: Medicare Supplement Policy Plan A). (b) An indication that the policy is a Medicare Supplement policy. (c) A provision indicating that the policy coverage shall be guaranteed renewable and that the insurer reserves the right to change premiums and any renewal premium increases. | <input type="checkbox"/> | <input type="checkbox"/> |
| | | 8. The policy displays a notice that states "Notice to buyer: This policy may not cover all of your medical expenses." The notice appears prominently on the first page of the policy by type, stamp, or other appropriate means. OAR 836-052-0175(1)(c) | <input type="checkbox"/> | <input type="checkbox"/> |
| | | 9. The policy includes a table of contents that clearly identifies where to locate the provisions. ORS 743.106(1)(d). | <input type="checkbox"/> | <input type="checkbox"/> |
| Clarity/ readability | ORS 742.005(2) | Forms are clear and understandable in their presentation of premiums, labels, description of contents, title, headings, backing, and other indications (including restrictions) in the provisions. The information is clear and understandable to the consumer and is not unintelligible, uncertain, ambiguous, abstruse, or likely to mislead. | Yes <input type="checkbox"/> | N/A <input type="checkbox"/> |
| | ORS 743.106(1)(d), ORS 743.103 | Policy and certificate contain a table of contents or index of the principal sections if longer than three pages or over 3,000 words. | Yes <input type="checkbox"/> | N/A <input type="checkbox"/> |

| Review Requirements | Reference | Description of Review Standards Requirements | Check answer or enter page & paragraph |
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| Form numbers | ORS 743.405(7) | All forms must include a uniform form number in the lower left-hand corner of each page. The policy and certificate are filed under one form number which provides core coverage with all the basic requirements. Basic policy requirements are not bracketed unless an alternative selection is included. Additional optional benefits to the policyholder are filed under separate form numbers. | Yes <input type="checkbox"/> N/A <input type="checkbox"/> |
| Limits | OAR 836-052-0160(1)(b) | Each rider or endorsement added to the policy at the date of issue or at reinstatement or renewal that reduces or eliminates benefits or coverage, requires a signature of acceptance by the insured. | Yes <input type="checkbox"/> N/A <input type="checkbox"/> |
| Variable data | ORS 742.005(2) | Variable data must be bracketed. Identify all applicable options or ranges of variables. The variable data maybe included within the policy and certificate or submitted as a separate form, identified by a form number (Example of bracketed variable: <i>Maximum benefits [\$5,000-\$200,000]</i>). The minimum and maximum variables must be included in an actively marketed plan. | Yes <input type="checkbox"/> N/A <input type="checkbox"/> |

(Skip to Requirements for Rates if only filing a rate change.)

| POLICY PROVISIONS | | | Page & paragraph or check answer |
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| Arbitration | ORS 36.600 to ORS 36.740 | Voluntary arbitration is permitted by the Oregon Constitution and statutes after all internal appeal levels and can be binding by consent of the covered participant. <i>(If the policy provides for arbitration when claim settlement cannot be reached, the enrollee may elect arbitration by mutual agreement at the time of the dispute. Arbitration takes place under the laws of Oregon held in the insured's county or another place agreed upon at the insured's option.)</i> | |
| Benefit reimbursement | OAR 836-052-0133, OAR 836-052-0136 | Medicare Supplement benefit plans A - L, include all required standard benefits outlined in OAR 836-052-0133 and OAR 836-052-0136. | Yes <input type="checkbox"/> N/A <input type="checkbox"/> |
| | OAR 836-052-0139(8)(a) and (b) | A Medicare Select policy or certificate includes a provision that pays for covered services provided by non-network providers if the services are for symptoms requiring emergency care or when immediate care is required. In addition to services provided by a non-network provider when it is not reasonable to obtain services through a network provider. | |
| | OAR 836-052-0139(9) | A Medicare Select policy or certificate includes provisions that pay for full coverage of covered services that are not available through network providers. | |

| Review Requirements | Reference | Description of Review Standards Requirements | Check answer or enter page & paragraph |
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| Benefit reimbursement | OAR 836-052-0139(10)(c) | A Medicare Select policy or certificate includes 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. | |
| Cancellation and nonrenewal | OAR 836-052-0133(2)(e)(B) | The insurer cannot cancel or non-renew the policy for any reason other than non-payment of premium or material misrepresentation discovered within two years after the policy effective date. | |
| Claim forms | ORS 743.426 | Upon receipt of a notice of claim, the insurer will furnish to the claimant such forms which are usually furnished by it for filing proof of loss. If such forms are not furnished within 15 days after the giving of such notice of claim, the claimant shall be deemed to have complied with the requirements of the policy. | |
| Claims settlement | OAR 836-052-0139(12) | Medicare Select forms explain procedures for handling complaints and grievances in a mutually agreed upon manner. | |
| Continuation of coverage | OAR 836-052-0139(15) | Medicare Select forms provide for continuation of coverage in the event the Secretary of HHS determines that Medicare select policies/certificates should be discontinued due to failure of the Medicare Select Program or its substantial amendment. | |
| Definitions | OAR 836-052-0119(13) | A Medicare Supplement policy does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under Sec. 1833(a)(1)(A) of the Social Security Act. | |
| | OAR 836-052-0124 | The Medicare Supplement policy or certificate contains definitions or terms that conform to the requirements prescribed under this section. | |
| | OAR 836-052-0139(3) | Medicare Select forms conform to definitions outlined within this section. | |
| Eligibility | OAR 836-052-0138 | Filing includes open-enrollment standards. The disabled may not be treated different than those who qualify by reason of age. | |
| | OAR 836-052-0142(3) | Guaranteed-issue periods are 63 days, according to the qualified provision. | Yes <input type="checkbox"/> N/A <input type="checkbox"/> |

| Review Requirements | Reference | Description of Review Standards Requirements | Check answer or enter page & paragraph |
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| Eligibility | OAR 836-052-0142(2) | <p>“Eligible persons,” is defined as one of the following:</p> <ul style="list-style-type: none"> (a) An individual enrolled under an employee welfare benefit plan that: (1) supplements the benefits under Medicare and the plan terminates or ceases to provide all supplemental health benefits; or (2) is primary to Medicare and the plan terminates or ceases to provide all health benefits. (b) An individual enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the circumstances apply under OAR 836-052-0142(2)(b), or the individual is 65 years of age or older and is enrolled with a program of All Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to those described in this subsection that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a Medicare Advantage plan. (c) An individual enrolled with an eligible organization defined in OAR 836-052-0142(2)(c)(A) and (B). (d) An individual enrolled under a Medicare Supplement policy and the enrollment ceases due to circumstances described in OAR 836-052-0142(2)(d). (e) An individual enrolled under a Medicare Supplement policy and terminates enrollment and subsequently enrolls under circumstances prescribed in OAR 836-052-0142(2)(e)(A) and (B). (f) An individual, upon first becoming enrolled for benefits under Medicare part A, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program no later than 12 months after the effective date of enrollment. (g) An individual enrolled in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare Supplement policy and submits evidence in Medicare Part D along with the application for a policy described in OAR 836-052-0142(5)(d). | <p>Yes</p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> |
| | OAR 836-052-0143 | The policy or certificate has a provision for the birthday selection rule that includes the following “Beginning on a person’s birthday, and for 30 days after, a Medicare supplement policy owner may cancel their existing Medicare supplement policy or certificate and purchase another Medicare supplement policy or certificate with the same or lesser benefits to replace the existing policy or certificate.” | |

| Review Requirements | Reference | Description of Review Standards Requirements | Enter page & paragraph |
|-------------------------------------|---|--|------------------------|
| Entire contract | ORS 743.411 | The policy, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. | |
| Examination of contract (Free look) | ORS 743.686; OAR 836-052-0160(1)(e) | The policy or certificate has a notice printed prominently on the first page of the policy or certificate or attached thereto stating that the applicant has the right to return the policy or certificate within 30 days of its delivery and have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. | |
| Grace period | ORS 743.417 | A minimum grace period of 10 days after the premium due date will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force. | |
| Legal actions | ORS 743.441 | A provision for legal actions includes the following: "No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished." | |
| Medicare supplement: standard plans | OAR 836-052-0136 | Policies comply with the standard Medicare Supplement benefit plans. | |
| | OAR 836-052-0136(5)(i)-(k), OAR 836-052-0129(4)(b) | The outpatient prescription drug benefit shall not be included in the Medicare supplement benefit plan "H" - "J", sold after December 31, 2005. | |
| | OAR 836-052-0136(5)(L), OAR 836-052-0129(4)(b) | The outpatient prescription drug benefit shall not be included in a Medicare Supplement benefit high deductible plan "J", sold after December 31, 2005. | |
| | OAR 836-052-0136(6), OAR 836-052-0133(5) | Include the make-up of two additional Medicare Supplement benefit plans, "K" and "L," as mandated by The Medicare Prescription Drug Improvement, and Modernization Act of 2003 (MMA), as described in OAR 836-052-0133(5). | |
| | OAR 836-052-0151(2) | Any riders or amendments to policy or certificate forms shall be filed only with the Insurance Commissioner in the state in which the policy or certificate was issued. In order to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. | |
| | OAR 836-052-0119(13) | Medicare Supplement policy does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under Sec. 1833(a)(1)(A) of the Social Security Act. | |
| | OAR 836-052-0151(4)(a) | A new or innovative benefit is offered in addition to one of the 12 (Group) or 8 (Individual) standardized Medicare Supplement benefit plans. <i>(To qualify, the insurer is required to pay some portion of the cost of a covered item or service rather than arranging for a reduced price for the item or service.)</i> | |

| Review Requirements | Reference | Description of Review Standards Requirements | Enter page & paragraph |
|-------------------------------|--|--|------------------------|
| Notice of claim | ORS 743.423(1) | Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy or as soon thereafter as is reasonably possible. | |
| Other insurance | ORS 743.683 | The policy does not contain benefits that duplicate benefits provided by Medicare. | |
| Payment of claims | OAR 836-052-0133(3)(c) | The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance. | |
| | | Payment of claims include the following provision: 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 payment, subject to a lifetime maximum benefit of an additional 365 days. | |
| | ORS 743.435 | A provision for payment of claims includes the following: "Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment, which may be prescribed herein and effective at the time of payment. If no such designation or provision is in effect, such indemnity shall be payable to the estate of the insured." | |
| | OAR 836-052-0140 | Provisions for claims handling are in compliance with OAR 836-052-0140. | |
| Payment plans | OAR 836-052-0139(6)(a)(E) | Medicare Select forms describe supplemental charges or coinsurance amounts payable by the insured that does not allow for providers to bill or seek reimbursement for covered services. | |
| Physical examination/ autopsy | ORS 743.438 | The insurer, at its own expense, has the right to examine any person covered by the insured, when and as often as it maybe reasonably required, while a claim is pending. | |
| Pre-existing conditions | OAR 836-052-0160(1)(d) | If the policy or certificate contains any limitations with respect to pre-existing conditions, such limitations must appear in a separate paragraph of the policy and labeled "Pre-existing Condition Limitations." | |
| | ORS 743.683(5), OAR 836-052-0133(2)(a)(B) | The policy does not define a pre-existing condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the policy's effective date. | |
| | ORS 743.683(5), OAR 836-052-0133(2)(a)(A) | The policy does not deny a claim for loss incurred more than six months from the effective date of coverage for a pre-existing condition. | |

| Review Requirements | Reference | Description of Review Standards Requirements | Enter page & paragraph |
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| Pre-existing conditions, continued | OAR 836-052-0190(1) | If the policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer waives any time periods applicable to pre-existing conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy to the extent such time was spent under the original policy. | |
| | OAR 836-052-0143(2) | Issuers may not deny or condition the issuance or effectiveness or discriminate in the pricing of the replacement policy or certificate on the basis of health status, claims experience, receipt of health care or medical condition of the applicant when applicants and policy holders elect to use OAR 836-052-0143. | |
| Prescription drug | OAR 836-052-0129(4)(b) | A Medicare Supplement policy with benefits for outpatient prescription drugs may not be issued after December 31, 2005. | |
| | OAR 836-052-0133(4)(f) | For Medicare Supplement Benefit Plans "B" - "J," the Basic Outpatient Prescription Drug benefit, may be included for sale or issuance in a Medicare Supplement policy until January 1, 2006. | |
| | OAR 836-052-0133(4)(g) | For Medicare Supplement Benefit Plans "B" - "J," the Extended Outpatient Prescription Drug benefit, may be included for sale or issuance in a Medicare Supplement policy until January 1, 2006. | |
| | OAR 836-052-0136(5)(i)-(l) | For Medicare Supplement Benefit Plans "H" to "J," the Outpatient Prescription Drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005. | |
| | OAR 836-052-0136(7) | If the policy or certificate contains new or innovative benefits, the innovative benefit shall not include an outpatient drug benefit after December 31, 2005. | |
| Primary coverage | OAR 836-052-0133 | Filing complies with benefit standards for policies or certificates issued for delivery on or after July 1, 1992. | |
| Proof of loss | ORS 743.429 | A statement in the policy shall contain a provision as follows: "PROOF OF LOSS: Written proof of loss must be furnished to the insurer at its office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required." | |

| Review Requirements | Reference | Description of Review Standards Requirements | Enter page & paragraph |
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| Reinstatement | ORS 743.420 | Provision states that if the renewal premium has not been paid within the time granted and an insurer or authorized agent accepts a subsequent premium it shall reinstate the policy. The only exception is an application for reinstatement required to be submitted by the enrollee and accepted by the insurer. | |
| Renewability | OAR 836-052-0129(4)(a) | Subject to OAR 836-052-0133(2)(d) and (e), and OAR 836-052-0134(2)(d), (e), and (g), the policy or certificate has a provision that allows a Medicare Supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006, to be renewed for current policyholders who do not enroll in Part D at the option of the policyholder. | |
| | OAR 836-052-0129(4)(b) | No Medicare Supplement policy with benefits for outpatient prescription drugs will be issued after December 31, 2005. | |
| | OAR 836-052-0129(4)(c) | After December 31, 2005, the policy with benefits for outpatient prescription drugs is not renewable after the policyholder enrolls in Medicare Part D, unless conditions meet those outlined under OAR 836-052-0129(4)(c)(A) and (B). | |
| | OAR 836-052-0133(2)(e) | The policy is guaranteed renewable. | |
| | OAR 836-052-0133(2)(e)(G), OAR 836-052-0134(2)(g) | A policy or certificate that eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, shall be deemed to satisfy the guaranteed renewal requirements. | |
| | OAR 836-052-0133(2)(f) | The policy or certificate includes a provision where the receipt of Medicare Part D benefits will not be considered in determining a continuous loss. | |
| | OAR 836-052-0134(2)(d) | A “noncancelable,” “guaranteed renewable,” or “noncancelable and guaranteed renewable” policy shall meet requirements outlined under this section. | |
| | OAR 836-052-0151(4)(a) | Innovative benefits are guaranteed renewable if filed as an integral part of the policy. | |
| | OAR 836-052-0151(4)(a) | Innovative benefits are not guaranteed renewable if filed as an optional rider, the rider is offered to all policyholders (with a particular plan) or to none of them. The innovative benefit is offered only with one of the 10 standardized Medicare-supplement benefit plans. <i>To qualify, the insurer pays a portion of the cost of a covered service or item and does not arrange for a reduced price for that service or item.</i> | |

| Review Requirements | Reference | Description of Review Standards Requirements | Check answer or enter page & paragraph |
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| Renewability | OAR 836-052-0151(5)(A) and (B), and Form 440-2896 | If this filing contains a discontinuance of a policy form or certificate form for new issues, a transmittal Form 440-2896 is submitted and approved. The insurer shall continue all outstanding policies and certificates in existence under the discontinued policy or certificate form. <i>(Discontinuance or availability of a policy or certificate form will be subject to a 5-year ban. The insurer will be prohibited from filing for approval a new policy form or certificate form of the same type during the ban period.)</i> | Yes <input type="checkbox"/> N/A <input type="checkbox"/> |
| | OAR 836-052-0160(1)(a) | Renewal or continuation provision is on the first page of the policy. This includes any automatic renewal premium increases based on the policyholder's age. | |
| | OAR 836-052-0160 | The insurer will notify the policyholder no later than 30 days prior to the annual effective date of any Medicare benefit change; benefit modifications and any premium adjustment requiring prior approval. | |
| Suspension | OAR 836-052-0133(2)(g)(A) | The policy contains a provision stating that the benefits and premiums under the policy may be suspended upon request by the policyholder for a period not to exceed 24 months. (The policyholder must notify the insurer within 90 days after the date that the policyholder becomes entitled to assistance by Medicaid.) | |
| | OAR 836-052-0133(2)(g)(D) | If there is suspension, then reinstatement of the policy occurs pursuant to the applicable provisions outlined in OAR 836-052-0133(2)(g)(D). | |
| | OAR 836-052-0133(2)(g)(D)(ii) | If the suspended Medicare Supplement policy provided coverage for outpatient prescription drugs, reinstatement of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension. | |
| Time limits on defenses | ORS 743.414 | After two years from the date of policy issue, no misstatements except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or deny a claim. | |
| Time payment of claims | ORS 743.432 | A provision for time of payment of claims includes the following: "Indemnities payable under this policy will be paid immediately upon receipt of due written proof of loss. Losses for which this policy provides periodic payment will be paid (insert period for payment, which must not be less frequently than monthly)." | |

RATE REQUIREMENTS

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|-------------------------|-----------------------------|--|---|
| Rate change filing | ORS 743.018, ORS 742.023 | Premium changes are subject to prior approval and should not be filed more than once in a twelve-month period. | |
| | ORS 742.003 | The following review is requested: 1. New rate filing. 2. Rate change. 3. Informational. | Requested <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| | OAR 836-010-0011 | Mark the type of health underwriting filed for the forms included in this rate request: 1. Full underwriting. 2. Simplified underwriting. 3. No underwriting. | Check one <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Actuarial certification | National standard | Actuarial memorandum is signed by an accredited actuary. | Yes <input type="checkbox"/> |
| Loss ratio standards | OAR 836-010-0021(1) | Successive generic policy forms of similar benefits covering generations of policyholders must be combined in the calculation of premium rates and loss ratios. | Yes <input type="checkbox"/> |
| | OAR 836-052-0145(1)(b) | Aggregate benefits shall be calculated on the basis of incurred claims experiences or health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premium for the period. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include services outlined in this subsection. | Yes <input type="checkbox"/> |
| | OAR 836-052-0145(2)(c) | Refund and credit calculations on policies or certificates issued prior to September 1, 2003, shall be made separately for all individual policies, including all group policies subject to an individual loss ratio standard when issued, combined and all other group policies combined for experience after January 1, 2006. | Yes <input type="checkbox"/> |
| Ratemaking generally | Form 440-2462 | Appendix A must be filed supporting the rate change requested, plus projections for a 10-year period, and the overall loss ratio from policy inception for Oregon and your company's national experience. The lines in Appendix A should be labeled to clarify whether they relate to historical or future projected experience. See Web site: http://dfr.oregon.gov/rates-forms/health/Pages/health.aspx | Yes <input type="checkbox"/> |

| Review Requirements | Reference | Description of Review Standards Requirements | Check answer |
|----------------------|------------------|--|---------------------------------|
| Ratemaking generally | OAR 836-010-0011 | A complete actuarial memorandum with a description of all policy benefits is included. Specific information on medical trend and lapse assumptions should be included. | Yes <input type="checkbox"/> |
| | | Data includes the expected experience of the new rate or existing rate for the projected calculating period over which the actuary expects the premium rates to remain adequate, based on estimated future experience and no expected rate increases. | Yes <input type="checkbox"/> |
| | | Information includes the source of the data, any new or experimental benefit, any concerns about the reliability of projections, any abrupt changes in the experience, and any substantial differences between the actual and expected experience are included. In addition to an accumulated historical loss ratio, estimated accumulated future loss ratios and accumulated lifetime loss ratios should be provided, assuming no increase, and also assuming the requested increase. This data should be shown not only for each distinct plan type, but also for the entire blow of business covered by the filing. | Yes <input type="checkbox"/> |
| | | A statement that the grouping of policy forms has not changed or all changes are fully explained. Experience of forms must be grouped with respect to similar types of benefits, claims experience, reserves, margins for contingencies, expenses and profit, renewability, underwriting, and equity between policyholders. | Yes <input type="checkbox"/> |
| | | The premium structure, as defined by the classification of insureds in the policy, is not changed at the time of rate increase (e.g., issue age basis to attained age basis). | Yes <input type="checkbox"/> |