

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

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**Standard Provisions for Individual and Group Standardized 2010 and 2020 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. Filings that do not include required information or policy provision will result in delays of delays of the filing..

INSURER NAME: _____

DATE: _____

- TOI (type of insurance):**
- MS07I Individual Medicare supplement - Medicare select
 - MS08I Individual Medicare supplement - Standard plans

 - MS07G Group Medicare supplement - Medicare select
 - MS08G Group Medicare supplement - Standard plans
 - MS09 Medicare supplement - Other

Sub TOI:

- MS07I.001 to .014 All plans Specific plans (*identify*) _____
- MS08I.001 to .013 All plans Specific plans (*identify*) _____

- MS07G.001 to .014 All plans Specific plans (*identify*) _____
- MS08G.001 to .013 All plans Specific plans (*identify*) _____
- MS09.000 Other

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, 440-2441A or 440-2441D, found on our website at:

<http://dfr.oregon.gov/rates-forms/associations-trusts/Pages/index.aspx>

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F and high deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G ¹	K	L	M	N	C	F ¹
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply ³	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility Coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in [2019] ²						[\$5560] ²	[\$2780] ²			

¹ Plans F and G also have a high deductible option which require first paying a plan deductible of [\$2300] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

² Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit. The annual OOP limits are determined in accordance with section 1882(w)(2) of the Social Security Act. That provision prescribed an OOP limit for 2006 of \$4,000 for Plan K and \$2,000 for Plan L, and directed that these amounts increase each subsequent year by an appropriate inflation adjustment specified by the Secretary of the United States Department of Health & Human Services. For 2019 the calculation of the OOP limits is based on estimates of the United States Per Capita Costs (USPCC) of the Medicare program developed by CMS as published with the announcement of Calendar Year (CY) 2018 and CY 2019 Medicare Advantage (MA) payment rates.

³ Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to \$20 for some office visits and up to a \$50 co-payment for emergency room visits that do not result in an inpatient admission.

Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan “A” available. Some plans may not be available in your state.

Basic Benefits:

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or co-payments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance.

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
<p>*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2300] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$2300]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible.</p>							Out-of-pocket limit for 2019 \$[5560]; paid at 100% after limit reached	Out-of-pocket limit \$[2780]; paid at 100% after limit reached		

Review Requirements	Reference	Description of Review Standards Requirements	Check answer	
GENERAL REQUIREMENTS (FOR ALL FILINGS)				
Submission package requirements	SERFF or Oregon Division of Financial Regulation website: OAR 836-010-0011	https://dfr.oregon.gov/rates-forms/health/Pages/health.aspx . In order for your filing to be accepted, it must include the following documents: <ol style="list-style-type: none"> 1. Filing description or cover letter. 2. Third party filer's letter of authorization. 3. Certificate of compliance form signed by authorized person. 4. Readability certification. 5. Product standards for forms (this document). 6. Forms filed for approval. (If filing revised forms, include a highlighted/redline form version of the revised form to identify the modification, revision, or replacement language.) 7. Statement of Variability (see "Variability in forms" section). 8. Actuarial memorandum with an overview of the contents of the filing the reasons and procedures used to derive the rates. 	Yes	N/A
	Additional submission requirements for Medicare	The filing includes: <ol style="list-style-type: none"> 1. Related advertising material must be included for new products. ORS 742.009, ORS 743.687, OAR 836-052-0170 and OAR 836-052-0151(5)(a). 2. Outline of coverage ORS 743.685. <ul style="list-style-type: none"> • Medicare standard, OAR 836-052-0160(4), see Exhibit Appendix C; • Medicare Select, see OAR 836-052-0139(10) (12)(a). 3. Application for replacement coverage and notice of replacement form. OAR 836-052-0165(1)-(6), and OAR 836-052-0142. 4. Medicare select filings, a plan of operation. OAR 836-052-0139(5) and (6). 5. Medicare select filings, a current list of network providers. OAR 836-052-139(7)(b). 	Yes	N/A
Review requested	ORS 742.003(1), ORS 742.005(1), OAR 836-010-0011(4)	The following are submitted in this filing for review: <ol style="list-style-type: none"> 1. New policy and/or certificate must include related advertising material (ORS 742.009, ORS 743.687, OAR 836-052-0151(5)(a) and OAR 836-052-0170). 2. Changes to previously approved forms include highlighted/redline version. 3. Addition of supplemental options to previously approved plans. 	Yes	N/A

Review Requirements	Reference	Description of Review Standards Requirements	Check answer
Filing description on transmittal form		<p>The filing description (cover letter) includes the following:</p> <ol style="list-style-type: none"> Changes made to previously-approved forms or variations from other approved forms. Summary of the differences between prior approved like forms and the new forms. The differences between in-network and out-of-network, if applicable. <p>Note: If filing through SERFF, DFR recommends that the cover letter be included in a separate document under the Supporting Documentation tab rather than in the General Information tab. If the filing description under the General Information tab is used, post submission changes to this language are not allowed.</p>	<p>Yes N/A</p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p>
Advertising material	<p>ORS 742.009, ORS 743.687, OAR 836-052-0170, OAR 836-052-0175 OAR 836-052-0151(5)(a)</p>	<p>All Medicare Supplement marketing material must be filed for review prior to use.</p> <ol style="list-style-type: none"> Advertisements for existing products should be filed separately. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve months. See link at: Form 440-3308H For new products the marketing plan and related advertising material must be included in the same filing and it follows the standards for marketing Medicare Supplement policies as stipulated in OAR 836-052-0175. Please fill out Health Advertisement Form 440-3308H. 	<p>Yes N/A</p> <p><input type="checkbox"/> <input type="checkbox"/></p>
Variability in forms	<p>ORS 742.003 ORS 742.005(2) OAR 836-010-0011(4)</p>	<p>If filing revised forms, must include a highlighted/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.</p> <ul style="list-style-type: none"> Variable text includes all optional text, changes in language, and choices in terms or provisions. Variable numbers are limited to numerical values showing all ranges (minimum to maximum benefit amounts). Explanation must be clear and complete. The filing includes a certification that any change outside the approved ranges will be submitted for prior approval. Variability in forms may be described either through embedded Drafter's Notes or a separate Statement of Variability form. In general, Drafter's Notes are preferred. <p>Note: detailed variability instructions can be found at: http://dfr.oregon.gov/rates-forms/health/Pages/health.aspx</p>	<p>Yes N/A</p> <p><input type="checkbox"/> <input type="checkbox"/></p>

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

FORMS			
Review Requirements	Reference	Description of Review Standards Requirements	Check answer or enter page and paragraph
Associations/trusts/discretionary groups	ORS 731.098, ORS 731.486, ORS 743.522-524, Form 440-2441	If filing includes an association, trust, union trust, or discretionary group, additional filing requirements apply. Use Form 440-2441A <i>Transmittal and Standards for Group Health Coverage to be issued to an Association or Trust Group</i> or Form 440-2441D <i>Transmittal and Standards for Group Health Coverage to be issued to a Discretionary Group</i> .	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
Assumption certificates	Form 440-3637	File under checklist of standards for <i>Changes to Business Operations that Require a Filing</i> , Form 440-3637 .	Yes <input type="checkbox"/> N/A <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 <input type="checkbox"/> N/A <input type="checkbox"/>
	OAR 836-052-0165	The statements and questions contained on the application and for replacement coverage are required.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
Cover page	Disclosure ORS 742.005 OAR 836-010-011(2), OAR 836-052-0160	<ol style="list-style-type: none"> 1. The full corporate name of the insuring company appears prominently on the first page of the policy. 2. A marketing name or insurer's logo, if used on the policy, does not mislead as to the identity of the insuring company. 3. The insuring company address, consisting of at least a city and state, appears on the first page of the policy. 4. The signature of at least one company officer appears on the first page of the policy. 5. The individual certificate includes a 30-day 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). 6. A form-identification number appears in the lower left-hand corner of all forms and page numbers. (The form number is adequate to distinguish the form from all others used by the insurer.) 	Yes <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"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Review Requirements	Reference	Description of Review Standards Requirements	Check answer or enter page and paragraph
Cover page	Disclosure ORS 742.005 OAR 836-010-0011(2), OAR 836-052-0160	<p>7. The policy contains a brief caption that appears prominently on the cover page and describes the type of coverage.</p> <p>(a) A caption of the type of coverage provided identified by the letter of the standardized plan. (Example: Medicare Supplement Policy Plan A).</p> <p>(b) An indication that the policy is a Medicare Supplement policy.</p> <p>(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. OAR836-052-0160(1)(a).</p> <p>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).</p> <p>9. The policy includes a table of contents that clearly identifies where to locate the provisions. ORS 743.106(1)(d).</p>	<p>Yes N/A <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> <input type="checkbox"/></p>
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 ambiguous, abstruse, unintelligible, uncertain, or likely to mislead.	Yes N/A <input type="checkbox"/> <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 N/A <input type="checkbox"/> <input type="checkbox"/>
Clarity/ readability	ORS 742.005(2), ORS 743.405(5), OAR 836-052-0160, OAR 836-052-0165	The font should be uniform and not less than 12-point type. The style, arrangement, and overall appearance of the policy may not give prominence to any portion of the text.	Confirmed <input type="checkbox"/>
Form numbers	ORS 743.405(7), OAR 836-010-0011	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 N/A <input type="checkbox"/> <input type="checkbox"/>
Limits	OAR 836-052-160(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 N/A <input type="checkbox"/> <input type="checkbox"/>

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

POLICY PROVISIONS			
Review Requirements	Reference	Description of Review Standards Requirements	Check answer or enter page and paragraph
Arbitration	ORS 36.600 to ORS 36.740	<p>Voluntary arbitration is permitted by the Oregon Constitution and statutes.</p> <ul style="list-style-type: none"> • Either party may elect arbitration at the time of the dispute (after the claimant has exhausted all internal appeals if applicable); • Unless there is mutual agreement to use an arbitration process, the decision will only be binding on the party that demanded arbitration; • Arbitration will take place in the insured's county or at another agreed upon location; • Arbitration will take place according to Oregon law, unless Oregon law conflicts with Federal Code. • The process may not restrict the injured party's access to other court proceedings; • Restricting participation in a class action suit is permissible 	
Benefit reimbursement	OAR 836-052-0132(2), OAR 836-052-0141 (2010 plans)	Standard Medicare Supplement Benefit Plans A, B, C, D, F, F with High Deductible, G, M and N must include the basic core package prescribed in OAR 836-052-0132 and OAR 836-052-0141(1)(d).	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
	OAR 836-052-0132(1)(c)	This Medicare supplement policy 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.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
	OAR 836-052-0132(3)	<p>Additional benefits in the Medicare Supplement Benefit plans as provided by OAR 836-052-0141. Please show where the following are located in this contract.</p> <p>(a) Medicare Part A deductible benefit, providing coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period.</p> <p>(b) Medicare Part A deductible benefit, providing coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period.</p> <p>(c) Skilled Nursing Facility Care benefit, providing coverage for the actual billed charges up to the coinsurance amount 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.</p>	

Review Requirements	Reference	Description of Review Standards Requirements	Check answer or enter page and paragraph
Benefit Reimbursement	OAR 836-052-0132(3)	<p>Additional benefits in the Medicare Supplement Benefit plans as provided by OAR 836-052-0141. Please show where the following are located in this contract.</p> <p>(d) Medicare Part B Deductible benefit, providing coverage for 100 percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.</p> <p>(e) 100 percent of the Medicare Part B Excess Charges benefit, providing coverage for 100 percent of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.</p> <p>(f) Medically necessary emergency care in a foreign country, providing coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, when the care would have been covered by Medicare if provided in the United States and when the care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.</p>	
	Medicare Select OAR 836-052-0139(8)(a) and (b)	This 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.	
	Medicare Select OAR 836-052-0139(9)	This policy or certificate includes provisions that pay for full coverage of covered services that are not available through network providers.	
	Medicare Select OAR 836-052-0139(10)(c)	This 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.	
	Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery to Individuals Newly Eligible for Medicare on or after January 1, 2020.	<p>For 2020 plans, all standards and requirements of OAR 836-052-0141(1) shall apply with the following exceptions:</p> <p>(a) Standardized Medicare supplement benefit Plan C is redesignated as Plan D and shall provide the benefits contained in OAR 836-052-0141(5)(c) but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.</p>	

Review Requirements	Reference	Description of Review Standards Requirements	Enter page and paragraph
Benefit reimbursement (continued)	<p>Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery to Individuals Newly Eligible for Medicare on or after January 1, 2020.</p> <p>OAR 836-052-0144 OAR 836-052-0141</p> <p>Applicability to certain individuals</p>	<p>For 2020 plans, all standards and requirements of OAR 836-052-0141(1) shall apply with the following exceptions:</p> <p>(b) Standardized Medicare supplement benefit Plan F is redesignated as Plan G and shall provide the benefits contained in OAR 836-052-0141(5)(e) but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.</p> <p>(c) Standardized Medicare supplement benefit plans C, F and F With High Deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.</p> <p>(d) Standardized Medicare supplement benefit Plan F With High Deductible is redesignated as Plan G With High Deductible and shall provide the benefits contained in OAR 836-052-0141(5)(f) but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible; provided further that the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible.</p> <p>(e) The reference to Plans C or F contained in OAR 836-052-0141(1)(b) is deemed a reference to Plans D or G for purposes of this section.</p> <p>OAR 836-052-0144(2-4)</p> <p>(a) By reason of attaining age 65 on or after January 1, 2020; or</p> <p>(b) By reason of entitlement to benefits under Part A pursuant to section 226(b) or 226A of the Social Security Act, or who is deemed to be eligible for benefits under section 226(a) of the Social Security Act on or after January 1, 2020.</p> <p>(3) Guaranteed Issue for Eligible Persons. For purposes of OAR 836-052-0142, in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F With High Deductible) shall be deemed to be a reference to Medicare supplement policy D or G (including G With High Deductible).</p> <p>(4) Offer of Redesignated Plans to Individuals Other Than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in OAR 836-052-0144(1)(d) above may be offered to any individual who was eligible for Medicare prior to January 1, 2020 in addition to the standardized plans described in OAR 836-052-0141(5).</p>	

Review Requirements	Reference	Description of Review Standards Requirements	Check answer or enter page and paragraph
Cancellation and nonrenewal	OAR 836-052-0132(1)(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 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	Medicare Select OAR 836-052-0139(12)	Forms explain procedures for handling complaints and grievances in a mutually agreed upon manner.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
Continuation of coverage	Medicare Select OAR 836-052-0139(15)	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 to be reauthorized under law or its substantial amendment.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
	OAR 836-052-0132(1)(c)	If the Medicare supplement policy is terminated by the group policyholder and not replaced, the issuer shall offer continuation of the benefits.	
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.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
Discrimination	OAR 836-052-0124	The Medicare supplement policy or certificate contains definitions or terms that conform to the requirements prescribed under this section. Accident, Injury, Benefit Period, Convalescent Nursing Home, Health Care Expenses, Hospital, Medicare, Medicare Eligible Expenses, Physician, and Sickness.	
	Medicare Select OAR 836-052-0139(3)	Forms conform to definitions outlined within this section. (Complaint, Grievance, Medicare Select Issuer, Medicare Select Policy, Network Provider, Restricted Network Provision, and Service Area.)	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
	OAR 836-052-0132(1)(b)	This Medicare supplement policy shall not cover losses resulting from sickness on a different basis than losses resulting from accidents.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
	OAR 836-052-0138 (1)(4)(5)(a)(b)	The disabled may not be treated different than those who qualify by reason of age.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>

Review Requirements	Reference	Description of Review Standards Requirements	Check answer or enter page and paragraph
Discrimination, continued	OAR 836-052-0192(2)(b)	A Medicare supplement policy shall not discriminate in the pricing of the policy including the adjustment of premium rates of an individual on the basis of the genetic information with respect to the individual.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
	OAR 836-052-0192(4)(7)	The policy or certificate shall not request or require a family member or individual to undergo a genetic test or genetic testing. Unless research complies with Code of Federal Regulations and the insurer communicates that compliance is voluntary and will not have effect on enrollment status or premium or contribution amounts.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
Eligibility	OAR 836-052-0138(1)	Filing includes open-enrollment standards.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
	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"/>
	OAR 836-052-0142(2)	<p>“Eligible persons” is defined as one of the following:</p> <p>(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.</p> <p>(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.</p> <p>(c) An individual enrolled with an eligible organization defined in OAR 836-052-0142(2) (c)(A) and (B).</p> <p>(d) An individual enrolled under a Medicare supplement policy and the enrollment ceases due to circumstances described in OAR 836-052-0142(2)(d).</p> <p>(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).</p> <p>(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.</p>	<p>Yes <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>

Review Requirements	Reference	Description of Review Standards Requirements	Check answer or enter page and paragraph
Eligibility, continued	OAR 836-052-0142(2)(g), OAR 836-052-0142(5)(d)	(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).	<input type="checkbox"/>
	OAR 836-052-0192(2)(a)	An issuer of Medicare supplement policy or certificate shall not: Deny or condition the issuance or effectiveness of the policy or certificate including imposition of any exclusion of benefits under the policy based on a pre-existing condition on the basis of genetic information.	Yes <input type="checkbox"/>
	OAR 836-052-0192(7)(c)	No genetic information collected or acquired may be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or placement of a policy or certificate.	Yes <input type="checkbox"/>
	OAR 836-052-0192(8)(9)	An issuer of Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.	Yes <input type="checkbox"/>
	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."	
	ORS 746.160, OAR 836-052-0156, Bulletin 2009-2	An issuer or other entity may not provide greater incentives selling to healthy people over those with a guaranteed right to coverage who may have medical conditions. Commission rates cannot be lower for guaranteed-issue business than for the same age person who enrolls outside a guaranteed-issue period and is underwritten.	
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-premium/rates	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.	
Premium/rates	OAR 836-052-0145(3)(b), OAR 836-052-0151(2)(b)	The policy includes a statement that rates will only increase once in a 12 month period.	

Review Requirements	Reference	Description of Review Standards Requirements	Check answer or enter page and paragraph
Inducements not specified in policy	ORS 746.035	Except as otherwise expressly provided by the Insurance Code, no person shall permit, offer to make or make any contract of insurance, or agreement as to such contract, unless all agreements or understandings by way of inducement are plainly expressed in the policy issued thereon.	Page: Paragraph or Section:
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."	
Primary coverage	OAR 836-052-0132, OAR 836-052-0141	This filing seeking approval for a policy or certificate containing new and innovative plans complies with all regulation stipulation on OAR 836-052-0132 and OAR 836-052-0141.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
Medicare supplement: standard plans	OAR 836-052-0141(5)	Plans to be offered for sale include only the following: Plan A, Plan C, Plan D, Plan F, Plan F with high deductible, Plan G, Plan K, Plan L, Plan M, and Plan N.	
	OAR 836-052-0141	If an insurer makes available any of the additional benefits described in OAR 836-052-0132(3) or offers standardized benefit Plans K or L, then standardized Plan C or Plan F must also be offered.	
	OAR 836-052-0141(5)(g), OAR 836-052-0141(h) and (i)	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 836-052-0141(5).	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
	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.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
	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.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
	OAR 836-052-0151(4)(a), Social Security Act Section 1882(p)(4)(B) Innovative benefits	A new or innovative plan may be offered in addition to standardized Medicare supplement benefit plans. The new or innovative plan may include benefits that are appropriate to Medicare supplement insurance, not otherwise available, cost effective, and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
Newly Eligible	OAR 836-052-0119(14) OAR 836-052-0144	Individuals who become eligible for Medicare due to age, disability or end-stage renal disease on or after January 1, 2020	

Review Requirements	Reference	Description of Review Standards Requirements	Check answer or enter page and 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.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
Payment of claims	OAR 836-052-0132(2)(c)	The policy contains a provision indicating: 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 of payment, subject to a lifetime maximum benefit of an additional 365 days.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
	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."	
	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)."	
	OAR 836-052-0140	Provisions for claims handling are in compliance with OAR 836-052-0140.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
Payment plans	Medicare Select OAR 836-052-0139(6)(a)(E)	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.	Yes <input type="checkbox"/> N/A <input type="checkbox"/>
	OAR 836-052-0141(4)	An issuer of Medicare supplement policy or certificate shall not request or require an individual or family member of the individual to undergo a genetic test. If a request is made by the insurer, compliance with the request shall be voluntary and non-compliance will have no effect on enrollment status, premium or contribution amounts per OAR 836-052-0141.	Yes <input type="checkbox"/> No <input type="checkbox"/>
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."	

Review Requirements	Reference	Description of Review Standards Requirements	Check answer or enter page and paragraph
Pre-existing conditions, continued	OAR 836-052-0132(1)(a)(A)(B), ORS 743.683(5)	The policy shall not exclude or limit benefits for loss incurred more than six months after the effective date of coverage because the loss involved a pre-existing condition. The policy shall 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 effective date of coverage.	
	ORS 743.683(5), OAR 836-052-0132(1)(a)	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.	
	OAR 836-052-0132(1)(E)	If a group Medicare supplement policy is replaced by another group Medicare supplement policy, the issuer of the replacement policy shall not result in any exclusion for pre-existing conditions that would have been covered under the group policy being replaced.	Yes <input type="checkbox"/> No <input type="checkbox"/>
	OAR 836-052-0143(2)	The policy does 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.	Yes <input type="checkbox"/> No <input type="checkbox"/>
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. Does this policy offer prescription drug coverage?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	OAR 836-052-0133(4)(f)(g)	For Medicare supplement benefit Plan "B" - the Basic Outpatient Prescription Drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006. Does the filing offer Plan "B"?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	OAR 836-052-0136(7), OAR 836-052-0141(6)	The filing complies with OAR 836-052-0141(6) in that the policy or certificate contains new or innovative benefits, but these innovative benefit do not include an outpatient drug benefit after December 31, 2005.	Yes <input type="checkbox"/> No <input type="checkbox"/>
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	Check answer or enter page and paragraph
Rebates	ORS 746.045	No person shall personally or otherwise offer, promise, allow, give, set off, pay or receive, directly or indirectly, any rebate of or rebate of part of the premium payable on an insurance policy unless disclosed in the policy.	Confirmed <input type="checkbox"/> NA <input type="checkbox"/>
Reinstatement	ORS 743.420 OAR 836-052-0160(1)(b)	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 836-052-0132 (1)(e)(A)(B)(C)(D)(E)	A Medicare supplement shall be guaranteed renewable and shall meet requirements outlined under this section.	
	OAR 836-052-0132(1)(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 836-052-0151(4)(a)	If filed as an optional rider, the innovative benefits are not guaranteed renewable, the rider is offered to all policyholders (with a particular plan) or to none of them.	Yes <input type="checkbox"/> No <input type="checkbox"/>
	OAR 836-052-0151(5)(A) and (B), and Form 440-2896	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 until the ban is lifted.)</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.	Yes <input type="checkbox"/> No <input type="checkbox"/>
	OAR 836-052-0160(2)(a)	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.	
	OAR 836-052-0132(1)(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 836-052-0132(1)(g)(A)	If there is suspension, then reinstatement of the policy occurs pursuant to the applicable provisions outlined in OAR 836-052-0132(1)(g)(A).	

Review Requirements	Reference	Description of Review Standards Requirements	Check answer or enter page and paragraph
Renewability, continued	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.	Yes <input type="checkbox"/> No <input type="checkbox"/>
	OAR 836-052-0132(1)(d)	A Medicare supplement policy or certificate shall 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.	Yes <input type="checkbox"/> No <input type="checkbox"/>
	OAR 836-052-0132(1)(f)	Termination of a Medicare supplement policy shall be without prejudice to any continuous loss which commenced while the policy was in force.	Yes <input type="checkbox"/> No <input type="checkbox"/>
	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.	
Suspension	OAR 836-052-0132(1)(g)(A)(D)	This policy shall provide the opportunity for suspension at the request of the policyholder or certificate holder for a period not to exceed 24 months.	

RATE REQUIREMENTS

Review Requirements	Reference	Description of Review Standards Requirements	Check answer or enter page and paragraph
Rate change filing	ORS 743.018, ORS 743.684, OAR 836-052-0145(3)	Premium changes are subject to prior approval and should not be filed more than once in a 12-month period. Annual rate filing requirement.	
	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 836-052-0145	Rates cannot increase more than once in a 12-month period.	Yes <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"/>

Review Requirements	Reference	Description of Review Standards Requirements	Check answer or enter page and paragraph
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"/>
	Form 440-2462	An Appendix A is included in filing 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 website: http://dfr.oregon.gov/rates-forms/health/Pages/health.aspx	Yes <input type="checkbox"/>
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. 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"/>
		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.	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"/>