Illinois Department of Insurance

320 West Washington Street
Springfield, IL 62767-0001

Medicare Supplement Checklist

TO BE COMPLETED BY COMPANY

Company Name:

SERFF TOI:

SERFF SUB TOI:

SERFF Tracking #:

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

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

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

Illinois is providing health insurance issuers a Web Portal through which rate filings and actuarial memorandum may be electronically reported. This reporting process does not replace existing requirements for the submission of these materials through SERFF.

Web Portal 2.1 User Guide – Link

Checklist Directions

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

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

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PART 1 - ALL POLICIES

SECTION A - GENERAL FILING REQUIREMENTS

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
1.A.1	Review Requirements Checklist	Review Requirements Checklists	Each filing must include a completed Review Requirements Checklist that must contain a completed "Location of Standard in Filing" column for each required element of the filing. Please indicate the proper page # and form # for each entry.	
1.A.2	Cover Letter and Letter of Submission	50 IAC 916.40(b)	Each filing shall be submitted directly through SERFF and shall include: (A) A detailed description of the purpose for the policy form and the manner in which it will be marketed; and (B) A cross-reference SERFF tracking number for identical submissions made by affiliated companies. -- The insurer shall file a letter of submission, or provide the following information in the Filing Description field under the General Information tab in SERFF, containing: (A) The name of the form, if any, and identifying form number; (B) Whether the submission is a new form; (C) If the form is intended to supersede another, the form number of the form replaced and the date it was approved by the Department, with all changes from the previously approved form highlighted.	
1.A.3	Outline of Coverage	215 ILCS 5/363a(6)(b) 50 IAC 2008.90(f) 50 IAC 2008.APPENDIX W	The outline of coverage shall consist of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer.	
1.A.4	Form Filing Requirements	50 IAC 916.40(b) 50 IAC 2008.81(a)	Each company shall file with the Director for approval each new policy form in a searchable text PDF before it is issued or delivered in this State.	
1.A.5	Rates	50 IAC 2008.80(a)(2) 50 IAC 2008.81(c) 50 IAC 916.40(e)(1)	An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the Director pursuant to 50 IAC 916. Individual and group Medicare supplement policy form filings shall be accompanied by rates providing a description of the classification of risks and the premium rates. Data demonstrating the calculation of the rates shall accompany each individual accident and health policy form. The rate data must be submitted in a separate SERFF filing. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this Section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.	
1.A.6	Certificate of Compliance	50 IAC 916.40(a)	Each company doing business in the State of Illinois shall submit with each filing a Certificate of Compliance.	

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SECTION A - GENERAL FILING REQUIREMENTS - *CONTINUED*				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
1.A.7	Annual Rate Filing	50 IAC 2008.80(c)	An issuer of Medicare supplement policies and certificates shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the Director in accordance with the filing requirements and procedures prescribed by the Director. The supporting documentation shall also demonstrate, in accordance with actuarial standards of practice using reasonable assumptions, that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than 3 years.	
1.A.8	Under Age 65 Rate Requirements	215 ILCS 5/363(6)(c) Company Bulletin 2008-02	Insurers must file a rate schedule which clearly shows that the under age 65 rates do not exceed the highest rate they charge to anyone over 65.	
1.A.9	Discretionary Authority	215 ILCS 5/143(1)	Insurers are not permitted to place discretionary authority language in contracts of accident and health.	
1.A.10	Use of SSN on ID Cards	215 ILCS 138/15 815 ILCS 505 2QQ	A person or entity may not print an individual's social security number on an insurance card. A person or entity that provides an insurance card must print on the card an identification number unique to the holder of the card in the format prescribed by Section 15 of the Uniform Prescription Drug Information Card Act.	
1.A.11	One Filing for Each Medicare Supplement Benefit Plan	215 ILCS 5/143(1)	Insurers may not file more than one form of a policy or certificate for each type of Standard Medicare Supplement Benefit Plan.	

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SECTION B - REQUIRED MEDICARE SUPPLEMENT PROVISIONS

Line	Review Requirement	Reference	Items that must be included with Filing	Location/Affirmed
1.B.1	Preexisting Conditions	50 IAC 2008.64 (a)(1)	A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage because it involved a preexisting condition.	
1.B.2	Medicare Cost Sharing	50 IAC 2008.64 (a)(3)	A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.	
1.B.3	Guaranteed Renewability	50 IAC 2008.64 (a)(5)	Each Medicare supplement policy shall be guaranteed renewable. The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.	
1.B.4	Riders/Endorsements	50 IAC 2008.90(a)(2)	The insured must agree in writing to policy or endorsements that reduce or eliminate benefits after coverage is in force or at the time of reinstatement.	
1.B.5	Usual and Customary	50 IAC 2008.90(a)(3)	Policies may not provide benefit payments based on standards described as "usual and customary", "reasonable and customary" or terms similar in nature.	
1.B.6	Pre-existing Limitations	50 IAC 2008.90(a)(4) 215 ILCS 5/363(5)	Policies containing pre-existing condition provisions must be placed in a separate paragraph and be labeled as "Preexisting Condition Limitations". A Medicare Supplement policy or certificate may not deny a claim for losses incurred more than 6 months from the effective date of coverage.	
1.B.7	Free Look	50 IAC 2008.90(a)(5) 215 ILCS 5/363(4)	Policies must contain a 30-day free look provision.	
1.B.8	Guide to Health Insurance for People with Medicare	50 IAC 2008.90(a)(6) 215 ILCS 5/363a(6)(c)	Issuers of Medicare Supplement policies that provide benefits on an expense incurred or indemnity basis must provide applicants with a Guide to Health Insurance for People with Medicare that has been approved by the Director.	
1.B.9	Identification Cards	50 IAC 2008.90(b)	Identification cards provided to the policyholder(s) must reflect the name of the issuer rather than a corporate name and must also identify which plan of coverage is being provided to the policyholder.	
1.B.10	Policy Checklist	50 IAC 2008.90(c) 50 IAC 2008.Appendix A 215 ILCS 5/363a(3)(f)	A policy checklist is required and must conform with Appendix A.	
1.B.11	Outline of Coverage	50 IAC 2008.90(f) 50 IAC 2008 Appendix B 215 ILCS 5/363a(6)(a)(b)	An outline of coverage is required. It must indicate all the plans and corresponding premium rates the insurer has available in Illinois. The cover letter must disclose the previously approved policy(s) form numbers and filing numbers as well as approval date for the previously approved filings to which the new rate filing applies.	

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SECTION B - REQUIRED MEDICARE SUPPLEMENT PROVISIONS - *CONTINUED*				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
1.B.12	Advertising Filing Requirements	50 IAC 2008.90(h)	An issuer of Medicare supplement insurance or benefits in this State shall provide a copy of any Medicare supplement advertisement intended for use in thie State to the Director for review.	
1.B.13	Application Forms	50 IAC 2008.100(a)	Application forms must include a replacement questions as specifically provided by 50 IAC 2008.100(a)(1) and (2).	
1.B.14	Replacement Notice	50 IAC 2008.100(d) & (e) 50 IAC 2008.Appendix R	Upon determining that a sale will involve replacement of Medicare supplement, an issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of accident and sickness coverage in the form prescribed in Appendix R	
1.B.15	Genetic Testing	50 IAC 2008.107	Insurers shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) on the basis of the genetic information with respect to that individual, nor shall they discriminate in the pricing of the certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to that individual.	

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SECTION C - STANDARDIZED MEDICARE SUPPLEMENT PLANS (A-L)				
PLEASE NOTE: APPENDICES AA THROUGH JJ ARE FOUND WITHIN APPENDIX W				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
1.C.1	Core Benefits	50 IAC 2008.Appendix W	Appendix W shows the benefits included in each of the standard Medicare supplement plans.	
1.C.2	Plan A	50 IAC 2008.67(b) 50 IAC 2008.67(c) 50 IAC 2008.Appendix W 50 IAC 2008.Appendix AA	Core Benefits plus Plan A Requirements in Appendix AA. • The core benefits.	
1.C.3	Plan B	50 IAC 2008.67(b) 50 IAC 2008.67(c) 50 IAC 2008.Appendix W 50 IAC 2008.Appendix BB	Core Benefits plus Plan B Requirements in Appendix BB. • The core benefits; and • 100% of the Medicare Part A deductible.	
1.C.4	Plan C	50 IAC 2008.67(b) 50 IAC 2008.67(c) 50 IAC 2008.Appendix W 50 IAC 2008.Appendix CC	Core Benefits plus Plan C Requirements in Appendix CC. • The core benefits; • 100% of the Medicare Part A deductible; • Skilled nursing facility care; • 100% of the Medicare Part B deductible; and • Medically necessary emergency care in a foreign country.	
1.C.5	Plan D	50 IAC 2008.67(b) 50 IAC 2008.67(c) 50 IAC 2008.Appendix W 50 IAC 2008.Appendix DD	Core Benefits plus Plan D Requirements in Appendix DD. • The core benefits; • 100% of the Medicare Part A deductible; • Skilled nursing facility care; and • Medically necessary emergency care in an foreign country.	
1.C.6	Plan F/ High Deductible Plan F	50 IAC 2008.67(b) 50 IAC 2008.67(c) 50 IAC 2008.Appendix W 50 IAC 2008.Appendix EE	Core Benefits plus Plan F Requirements in Appendix EE. • The core benefits; • 100% of the Medicare Part A deductible; • Skilled nursing facility care; • 100% of the Medicare Part B deductible; • 100% of the Medicare Part B excess charges; and • Medically necessary emergency care in a foreign country. ***Standardized Medicare supplement Plan F With High Deductible shall include 100% of covered expenses following the payment of the annual deductible.***	
1.C.7	Plan G	50 IAC 2008.67(b) 50 IAC 2008.67(c) 50 IAC 2008.Appendix W 50 IAC 2008.Appendix FF	Core Benefits plus Plan G Requirements in Appendix FF. • The core benefits; • 100% of the Medicare Part A deductible; • Skilled nursing facility care; • 100% of the Medicare Part B excess charges; and • Medically necessary emergency care in a foreign country.	

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SECTION C - STANDARDIZED MEDICARE SUPPLEMENT PLANS (A-L) - *CONTINUED*				
PLEASE NOTE: APPENDICES AA THROUGH JJ ARE FOUND WITHIN APPENDIX W				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
1.C.8	Plan K	50 IAC 2008.67(b) 50 IAC 2008.67(c) 50 IAC 2008.Appendix W 50 IAC 2008.Appendix GG	Core Benefits plus Plan K Requirements in Appendix GG. • Part A Hospital Coinsurance 61st through 90th days. • Part A Hospital Coinsurance, 91st through 150th days. • Part A Hospitalization After 150 Days. • 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met. • Coverage for 50% of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met. • Coverage for 50% of cost sharing for all Part A Medicare eligible expenses and hospice care until the out-of-pocket limitation is met. • Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood until the out-of-pocket limitation is met. • Coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met. • Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible. • Coverage of 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4000 in 2006.	
1.C.9	Plan L	50 IAC 2008.67(b) 50 IAC 2008.67(c) 50 IAC 2008.Appendix W 50 IAC 2008.Appendix HH	Core Benefits plus Plan L Requirements in Appendix HH. • Part A Hospital Coinsurance 61st through 90th days. • Part A Hospital Coinsurance, 91st through 150th days. • Part A Hospitalization After 150 Days. • Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible. • 75% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met. • Coverage for 75% of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met. • Coverage for 75% of cost sharing for all Part A Medicare eligible expenses and hospice care until the out-of-pocket limitation is met. • Coverage for 75%, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood until the out-of-pocket limitation is met. • Coverage for 75% of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met. • Coverage of 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $2000 in 2006.	

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SECTION C - STANDARDIZED MEDICARE SUPPLEMENT PLANS (A-L) - *CONTINUED*				
PLEASE NOTE: APPENDICES AA THROUGH JJ ARE FOUND WITHIN APPENDIX W				
Line	**Review Requirement**	**Reference**	**Items that must be included with Filing**	**Location/Affirmed**
1.C.10	Plan M	50 IAC 2008.67(b) 50 IAC 2008.67(c) 50 IAC 2008.Appendix W 50 IAC 2008.Appendix II	Core Benefits plus Plan M Requirements in Appendix II. • The basic (core) benefit; • 50% of the Medicare Part A deductible; • Skilled nursing facility care; and • Medically necessary emergency care in a foreign country.	
1.C.11	Plan N	50 IAC 2008.67(b) 50 IAC 2008.67(c) 50 IAC 2008.Appendix W 50 IAC 2008.Appendix JJ	Core Benefits plus Plan N Requirements in Appendix JJ. • The basic (core) benefit; • 100% of the Medicare Part A deductible; • Skilled nursing facility care; • Medically necessary emergency care in a foreign country; • Copayment of the lesser of $20 or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and • Copayment of the lesser of $50 or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.	

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Part 2 - MEDICARE SELECT POLCIES AND CERTIFICATES

SECTION A - GENERAL FILING GUIDELINES

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

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

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