

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Individual Medicare Supplement Insurance Checklist

(As of 11/09/16)

Instructions for Checklist:

- A. For **ALL** filings, the “General Requirements for All Filings” section **MUST** be completed.
- B. For a **FORM** filing, completion of additional sections may be required as follows depending on the type of form being submitted:
- Policy – Also complete the “Policy Forms” section.
- Rider or endorsement – Also complete all items in the “Policy Forms” section relevant to the form being submitted.
- Application – Also complete the “Applications” section.
- C. For filing of **RATES for NEW products**, complete the “New Products – Rate Requirements” section in addition to completion of the applicable form sections identified above.
- For filing of **RATE changes to EXISTING products** (increases/decreases), complete the “Instructions/Checklist for Filing Medicare Supplement Rate Adjustments” and accompanying exhibits at <http://www.dfs.ny.gov/insurance/ihealth.htm#msraf>
- For filing of any OTHER changes to RATE or underwriting manuals (e.g., change in rate calculation rules or procedures or changes in commissions or underwriting), complete the “Existing Products-Rate Requirements” section.
- D. Some items have shaded boxes. All of the items with shaded boxes must be answered. Some of the items in the checklist require an attachment or explanation. Failure to include required explanations or attachments or an incomplete explanation (such as “not applicable” or “see form”) will result in the filing being closed without further review.
- E. For each item, enter in the last column the form number(s), page number(s), and paragraph(s) where the requirement is met in the filing or insert a bookmark connecting to the appropriate location in the filing.
- F. Do not make any changes or revisions to this checklist.

Note: All citations to Insurance regulations link to the Department of State’s website and an unofficial copy of the NYCRR. Please select Title 11 for Insurance regulations. Most of the pertinent form and rate regulations are located in Chapter III Policy and Certificate Provisions; Subchapter A Life, Accident and Health Insurance.

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REVIEW STANDARDS FOR INDIVIDUAL MEDICARE SUPPLEMENT INSURANCE

LINE OF BUSINESS:	<u>Individual Medicare Supplement Insurance</u>	LINE(S) OF INSURANCE	CODES
CODE:	<u>MS071</u>	<u>Plan A</u>	<u>MS071.001</u>
		<u>Plan B</u>	<u>MS071.002</u>
		<u>Plan C</u>	<u>MS071.003</u>
		<u>Plan D</u>	<u>MS071.004</u>
		<u>Plan F</u>	<u>MS071.005</u>
		<u>Plan F+</u>	<u>MS071.006</u>
		<u>Plan G</u>	<u>MS071.007</u>
		<u>Plan K</u>	<u>MS071.008</u>
		<u>Plan L</u>	<u>MS071.009</u>
		<u>Plan M</u>	<u>MS071.010</u>
		<u>Plan N</u>	<u>MS071.011</u>

IF CHECKLIST IS NOT APPLICABLE, PLEASE EXPLAIN:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
KEY REFERENCES			
Insurance Law	§3102 , §3105 , §3201 §3216 , §3216(d) §3204	Form approval issues Standard provisions Contract/application issues	
Regulation 193	11NYCRR58	Minimum standards for form, content and sale of Medicare supplement insurance and Medicare Select insurance, including standards of full and fair disclosure.	
Regulation 169	11NYCRR420	Privacy of consumer financial and health information including Section 420.18.	
Regulation 34	11NYCRR215	Advertising	
DEFINITIONS			
Medicare Supplement	11NYCRR52.11	The definition of Medicare supplement insurance, provided in 11 NYCRR 52.11(a), is an individual or group policy or certificate of accident and health insurance that is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the	

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		<p>hospital, medical or surgical expenses of persons eligible for Medicare. This definition is applicable regardless of whether the policy form is labeled as Medicare supplement insurance.</p> <p>Medicare supplement insurance does not include the following (Section 52.11(b)):</p> <ul style="list-style-type: none"> a. a policy or certificate which provides continued coverage for persons beyond age 65 b. a policy or certificate issued pursuant to a contract under section 1876 of the Federal Social Security Act c. a policy or certificate issued under a demonstration project specified in 42 U.S.C. section 1395ss(g)(1) d. a policy or certificate offered through one or more employers or labor organizations, or through the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations; or e. Medicare Advantage plan under part C of Medicare 	
Guaranteed Renewable	11NYCRR58.1(b)(1) 11NYCRR58.1(b)(2)	<p>In Medicare supplement forms, the term “guaranteed renewable” means that the insured has the right to continue coverage in force by the timely payment of premiums and that the insurer has no unilateral right to make any change in any provision of the policy or certificate form while the insurance is in force, except to change benefits designed to cover cost-sharing amounts under Medicare to coincide with any changes in the applicable Medicare deductible amount and co-payment percentage factors, to amend the policy to meet minimum standards for Medicare supplement insurance, or to revise premium rates on a class basis.</p>	
Creditable Coverage	11NYCRR58.1(a)(7)(i)	<p>The definition of “creditable coverage” as contained in Section 58.1(a)(7)(i) is:</p> <ul style="list-style-type: none"> a. a group health plan; b. health insurance coverage; c. part A or B of title XVIII of the Social Security Act (Medicare); d. title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928; e. chapter 55 of title 10, United States Code (CHAMPUS and TRICARE health care programs for the uniformed military services); f. a medical program of the Indian Health Service or of a tribal organization; g. a State health benefits risk pool; h. a health benefit plan offered under chapter 89 of title 5, United States Code (Federal 	

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		<p>Employees Health Benefits Program);</p> <ul style="list-style-type: none"> i. a public health plan; j. a health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. section 2504[e]); and k. Medicare supplement insurance, Medicare select coverage or Medicare Advantage. 	
GENERAL REQUIREMENTS FOR ALL FILINGS			Form/Page/Para Reference
FILING SUBMISSION			
Form Requirements	<p>11NYCRR52.31 §3102(c)(1)(G); 11NYCRR215.5(d)</p>	<p>Each form in the filing must meet the following requirements:</p> <ul style="list-style-type: none"> a. The provisions of this form are NOT misleading or unreasonably confusing. §§3217(b)(2), 52.1(c). b. The provisions of this form provide substantial economic value to the policyholder. §§3217(b)(5), 52.1(c). c. The provisions of this form are NOT unjust, unfair, inequitable, misleading, or deceptive to the policyholder. §§3201(c)(3), 3217(b). d. This form contains no strikeouts. Section 52.31(b). e. All blank spaces are filled in with hypothetical data. Section 52.31(f). f. If the form contains more than 3 pages or more than 3,000 words, the form contains a table of contents. §3102(c)(1)(G). g. If the form contains variable material, the form contains minimal variable material and a full explanation of the nature and scope of the variable material is attached in the filing. Section 52.31(k) and (l). h. Explanations of variable material must contain the alternative language and should not state that the variable material will “conform to law” or will be “as requested by the policy holder”. Section 52.31(l) i. For all filings containing advertisements* that list URLs or use hyperlinks to navigate directly to other advertising content, an explanation must be included. The explanation must be contained in a section, included within the Explanation of Variability labeled “Links/Descriptions”. The “Links/Descriptions” supporting section must indicate when the content in question was filed, the form number, and the state tracking number. Please 	

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		include the "Links/Descriptions" section at the end of the Explanation of Variability document. The "Links/Descriptions" section should be on the same form as the Explanation of Variability. (*See 11 NYCRR 215.3 for the definition of advertisement). Section 215.5(d).	
Discrimination and Genetic Information	§2606, §2607 & §2608 11NYCRR58.1(i)	Unfair discrimination provisions because of race, color, creed, national origin, disability (including treatment of mental disability), sex, and marital status are prohibited. Additionally, Section 58.1(j) prohibits the use of genetic information and requests for genetic testing.	
Required Disclosure Form	11NYCRR Appendix 12A 11NYCRR Appendix 12B	The filing includes the required disclosure form that: Will accompany or be incorporated in the policy when delivered OR delivered to the applicant at the time application is made and receipt is acknowledged. Contains language that conforms to Appendix 12A or 12B of Regulation 193 depending on when the policy is issued. For policies issued prior to June 01, 2010, Appendix 12A should be used. For policies issued on or after June 01, 2010, Appendix 12B should be used.	
COVER PAGE			Form/Page/Para Reference
Company's name and address	§1102	New York State licensed entity.	
Company's home address		Full street address of the company's home office in prominent place (generally front and back of policy form) for disclosure purposes.	
Licensed entity only	§3201(c)(1)	No unlicensed entity in New York State should appear on the form.	
Product	11NYCRR52.11	Include name of product on the form within the defined category 52.11.	
Notice to Buyer	11NYCRR58.1(g)(iii)	Prominently display the notice: "Notice to buyer: This policy may not cover all of your medical expenses."	
Form Number	11NYCRR52.31(d)	Form identification number in lower left-hand corner of form.	
Free Look	11NYCRR58.1(b)(11)	Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery to the policyholder or certificate holder and to receive a full refund of any premium paid therefore including any policy fees or other charges.	
Renewal/Continuation Provisions	11NYCRR58.1(b)(2)	Medicare supplement insurance policies and certificates shall include a renewal or continuation provision contained on the first page of the policy or certificate and shall include any reservation by the issuer of the right to change premiums.	
Signature of Officer(s)		Signature of one or more company officers should appear on the face page to execute the contract on behalf of the company.	

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POLICY SCHEDULE PAGE			Form/Page/Para Reference
Blank Spaces	11NYCRR52.31(f)	Blank spaces of forms must be filled in and completed with hypothetical data.	
Spaces	11NYCRR52.31(f) 11NYCRR58.1(b) & (c)	Spaces for effective date of insurance, renewal dates and renewal terms.	
Cost-Sharing Amounts	11NYCRR58.1(b)(7)	Policies and certificates shall provide that benefits covering cost-sharing amounts under Medicare will be changed automatically to coincide with changes in the applicable Medicare deductible amount and co-payment percentages.	
Core Benefits	11NYCRR58.2(b)(5) 11NYCRR58.4 (b)(5)	The core benefits and any additional benefits according to the plan of coverage shall be listed. The core benefits for policies issued before June 01, 2010 are located within 11NYCRR58.2(b)(5). The core benefits for policies issued on or after June 01, 2010 are located within 11NYCRR58.4 (b)(5).	
Optional Benefits	11NYCRR52.31(f) §3204(a)(1)	Optional choices of insured regarding certain benefits and/or riders should be set forth.	
TABLE OF CONTENTS	§3102(c)(1)(G)	Table of Contents must be included when required by Section 3102 (c)(1)(G).	
POLICY FORMS			Form/Page/Para Reference
STANDARD PROVISIONS			
Entire Contract; Changes	§3216(d)(1)(A) §3204	This provision must be included and must be no less favorable to the insured than the statutory provision of §3216(d)(1)(A). This provision must also comply with §3204. There is no incorporation by reference.	
Time Limit on Defenses	§3216(d)(1)(B)	After two years from the date of issue of the policy no misstatements, except fraudulent misstatements, made by the applicant in the application shall be used to void the policy or deny a claim for loss incurred or disability commencing after the expiration of such two year period.	
Grace Period	§3216(d)(1)(C)	A grace period of (7 for weekly premium policies; 10 for monthly premium policies and 31 for all other policies) days 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.	
Reinstatement	§3216(d)(1)(D)	If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of the premium by the insurer, agent or broker, without requiring an application for reinstatement, shall reinstate the policy. If an insurer requires an application for reinstatement and issues a conditional receipt the policy will be reinstated upon approval of the application or upon the forty-fifth day following the date of the conditional receipt unless the insurer notifies the insured in writing of its disapproval.	
Notice of Claim	§3216(d)(1)(E)	The insured must have a minimum of 20 days to provide the insurer with notice of claim. Please note that failure to give notice within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as was reasonably possible.	

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Proof of Loss Forms	§3216(d)(1)(F)	The insurer must provide the policyholder or the claim filer, the forms necessary to file proof of loss within 15 days of notice of claim. If the insurer fails to provide such forms, the claim filer will be deemed to have complied with the requirements of the policy for filing proof of loss if, within the time period for filing such proof, the claims filer provides the insurer with written proof describing the occurrence, character and extent of the loss for which the claim is made.
Proof of Loss	§3216(d)(1)(G)	In the case of a claim for loss for which the policy provides for periodic payment contingent upon continuing loss, the insured must have a minimum of 90 days to provide the insurer with proof of loss. In all other cases, a minimum of 120 days after the date of such loss must be provided for the submission of such proof. Please note that failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as was reasonably possible, but in no event, except in the absence of legal capacity, later than one year.
Time Payment of Claims	§3216(d)(1)(H)	Indemnities payable for any loss, other than loss for which periodic payment is required, must be paid immediately upon receipt of written proof of such loss.
Payment of Claims	§3216(d)(1)(I)	Any indemnity for loss of life shall be payable in accordance with the beneficiary designation. If no such designation is then effective, such indemnity shall be payable to the estate of the insured.
Examination	§3216(d)(1)(J)	The insurer, at its own expense, shall have the right and opportunity to examine the insured making a claim as required during the pendency of the claim and the right and opportunity to conduct an autopsy in the case of death unless prohibited by law.
Actions	§3216(d)(1)(K)	60 days must pass after the filing of written proof of loss before an action at law or in equity may be brought to recover on the policy, but no action may be brought after 3 years has passed since the filing of written proof of loss.
Change of Beneficiary	§3216(d)(1)(L)	Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary(s) shall not be requisite to any changes in the policy.
FORM PROVISIONS		
Benefits	11NYCRR58.2(b)(3),(5),(6) and (c) 11NYCRR58.4(b)(3),(5),(6) and (c)	Benefits provided in a Medicare supplement insurance policy must be uniform in structure, language, designation, and format to the standard benefit plans "A" through "L" for policies issued before June 01, 2010 as specified in Sections 58.2(b)(3),(5),(6) and (c). Benefits provided in a Medicare supplement insurance policy must be uniform in structure, language, designation, and format to the standard benefit plans "A" through "N" for policies issued on or after June 01, 2010 as specified in Sections 58.4(b)(3),(5),(6) and (c).
Required Plans	11NYCRR58.2(b)(7)(i) 11NYCRR58.4(d)(7)(i)	For policies issued for an effective date before June 01, 2010, every Medicare supplement insurance issuer must offer at least Medicare supplement insurance benefit plans "A" and "B". For policies issued for an effective date on or after June 01, 2010, every Medicare supplement insurance issuer must offer at least Medicare supplement insurance benefit plans "A" and "B" and either "C" or "F".
Basic "Core" Benefits	11NYCRR58.2(b)(5) 11NYCRR58.4(b)(5)	For policies issued before June 01, 2010 benefit plans A – J must include the basic "core" benefits as listed in Section 58.2(b)(5).

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		<p>a. coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;</p> <p>b. coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;</p> <p>c. upon exhaustion of Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the costs incurred for hospitalization expenses of the kind covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days; benefits for hospitalizations occurring within New York State shall be paid in accordance with section 2807-c of the Public Health Law, where applicable;</p> <p>d. coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations) unless replaced in accordance with Federal regulations; and</p> <p>e. coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.</p> <p>For policies issued on or after June 01, 2010 benefit plans A-N must include the basic “core” benefits as listed in Section 58.4(b)(5).</p> <p>a. Coverage of part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;</p> <p>b. Coverage of part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;</p> <p>c. Upon exhaustion of Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the costs incurred for hospitalization expenses of the kind covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days. The issuer may enter into reimbursement contracts with provider hospitals to stand in the place of Medicare and to make payment for the hospitalization expenses at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, so long as there continues to be no cost to the insured person;</p> <p>d. Coverage under Medicare parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;</p>	
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		<p>e. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under part B regardless of hospital confinement, subject to the Medicare part B deductible; and</p> <p>f. Hospice Care: Coverage of cost sharing for all part A Medicare eligible hospice care and respite care expenses.</p>	
Additional benefits	<p>11NYCRR58.2(b)(6) 11NYCRR58.2(c) Appendix 12A</p> <p>11NYCRR58.4(b)(6) 11NYCRR58.4(c) Appendix 12B</p>	<p>For policies issued before June 01, 2010, Medicare supplement insurance benefit plan “A” contains the basic core benefits listed within 58.2(b)(5). Additional benefits are contained in plans “B” through “L” as follows:</p> <ol style="list-style-type: none"> a. Skilled nursing coinsurance – Plans “C” through “J”; Plan “K” at 50% and Plan “L” at 75% b. Part A deductible – Plans “B” through “J”; Plan “K” at 50% and Plan “L” at 75% c. Part B deductible – Plans “C”, “F”, “F+”, “J” and “J+” d. Part B excess – Plans “F” and “F+” (100%), “G” (80%), “I” (100%) and “J” and “J+” (100%) e. Foreign travel emergency – Plans “C” through “J” f. At home recovery – Plans “D”, “G”, “I” and “J” g. Preventive care – Plans “E” and “J” <p>For policies issued on or after June 01, 2010 Medicare supplement insurance benefit plan “A” contains the basic core benefits listed within 58.4(b)(5). Additional benefits are contained in plans “B” through “N” as follows:</p> <ol style="list-style-type: none"> a. Skilled nursing coinsurance – Plans “C”, “D”, “E”, “F”, “G”, “M”, “N”, Plan “K” at 50% and Plan “L” at 75% b. Part A deductible – Plans “B” through “G”; Plans “K” and “M” at 50%, Plan “L” at 75% and Plan “N” at 100% c. Part B deductible – Plans “C”, “F”, and “F+” d. Part B excess – Plans “F” and “G” e. Foreign travel emergency – Plans “C” through “G” 	
High Deductible Plans	11NYCRR58.2(c)(7) & (12)	High deductible plans “F” and “J” must comply with the requirement set forth in Section 58.2(c)(7) and (12), respectively. For 2010, the high deductible amount is \$2,000, which is adjusted annually. Please note that for policies issued on or after June 01, 2010 high deductible plan “J” will no longer be available.	
Plan K	11NYCRR58.2(c)(13)	For policies issued both before and after June 01, 2010 plan K includes the following:	

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	<p>11NYCRR58.4(c)(8)</p>	<ul style="list-style-type: none"> (i) Coverage of 100% of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period; (ii) Coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period; (iii) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance; (iv) Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (x); (v) Skilled Nursing Facility Care: 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 as described in Subparagraph (x); (vi) Hospice Care: Coverage for 50% of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subparagraph (x); (vii) Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph (x); (viii) Except for coverage provided in subparagraph (ix) below, 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 as described in Subparagraph (x) below; (ix) Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and (x) 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, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services. The amount for 2010 is \$4,620. 	
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Plan L	11NYCRR58.2(c)(14) 11NYCRR58.4(c)(9)	<p>For policies issued both before and after June 01, 2010 plan "L" includes:</p> <ul style="list-style-type: none"> (i) The benefits described in Plan K above, paragraphs (i), (ii), (iii) and (ix); (ii) The benefit described in Plan K above, paragraphs (iv), (v), (vi), (vii) and (viii), but substituting 75% for 50%; and (iii) The benefit described in Plan K above, paragraph (x), but substituting \$2,310 for \$4,620. 	
Plan M	11NYCRR58.4(c)(10)	<p>Plan M includes the following:</p> <ul style="list-style-type: none"> (i) Coverage of 100% of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period; (ii) Coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period; (iii) upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the costs incurred for hospitalization expenses of the kind covered by Medicare and recognized as medically necessary by Medicare, subject to a lifetime maximum benefit of an additional 365 days. The issuer may enter into reimbursement contracts with provider hospitals to stand in the place of Medicare and to make payment for the hospitalization expenses at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, so long as there continues to be no cost to the insured person; (iv) Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (x); (v) Coverage under Medicare parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations; (vi) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under part B regardless of hospital confinement, subject to the Medicare part B deductible; (vii) Hospice Care: Coverage of cost sharing for all part A Medicare eligible hospice care and respite care expenses; (viii) Skilled Nursing Facility Care: Coverage for 100% 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; and 	

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		<p>(ix) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty 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.</p> <p>Please note that Plan M will only be available for purchase on or after June 01, 2010.</p>	
Plan N	11NYCRR58.4(c)(11)	<p>Plan N includes the following:</p> <p>(i) the benefits described in Plan M above, paragraphs (i), (ii), (iii), (v), (vii), (viii) and (ix);</p> <p>(ii) the benefit described in Plan M above, paragraph (iv) but substituting 100% for 50%; and</p> <p>(iii) the lesser of twenty dollars (\$20) or the Medicare part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists) and the lesser of fifty dollars (\$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.</p> <p>Please note that Plan N will only be available for purchase on or after June 01, 2010.</p>	
New or Innovative Benefits	11NYCRR58.2(b)(6)(xi) 11NYCRR58.4(b)(6)(vii)	An issuer may submit new or innovative benefits to this Department for review and approval. Such benefits must meet the standards as outlined in Section 58.2(b)(6)(xi) for policies issued before June 01, 2010 or 58.4(b)(6)(vii) for policies issued on or after June 01, 2010.	
Duplicative Benefits	11NYCRR58.1(b)(5)	No Medicare supplement insurance policy or certificate in force in this State shall contain benefits which duplicate benefits provided by Medicare.	
Open Enrollment	11NYCRR58.1(i)(1) & (2)	An insurer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this State, nor discriminate in the pricing of such policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant regardless of whether an applicant is enrolled in Medicare by reason of age or disability. Applicants must be accepted at all times throughout the year for any Medicare supplement insurance benefit plan available from an issuer.	
Notice of Changes	11NYCRR58.1(m) 11NYCRR58.1(b)(10) 11NYCRR58.1(b)(1)(i)	<p>An issuer shall notify its Medicare supplement insurance policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates, not less than 30 days prior to the annual effective date of any Medicare benefit changes. Section 58.1(m).</p> <p>a. The notice shall include a description of the revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement insurance policy or certificate. Section 58.1(m)(1).</p> <p>b. The notice shall inform each policyholder and certificate holder as to when any premium adjustment is to be made due to changes in Medicare. Section 58.1(m)(2).</p>	

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		<p>c. The notice shall be in outline form and in clear and simple terms so as to facilitate comprehension. Section 58.1(m)(3).</p> <p>d. The notice shall not contain or be accompanied by any solicitation. Section 58.1(m)(4).</p> <p>With some exceptions, all riders or endorsements added to a Medicare supplement policy after the date of issue, reinstatement, or renewal, which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the insured. Section 58.1(b)(10).</p> <p>The insurer may not make unilateral changes to any provision of the policy or certificate while the insurance is in force except where the changes are required by law or to revise premium rates on a class basis with the approval of the superintendent. Section 58.1(b)(1)(i).</p>	
Termination	11NYCRR58.1(c)	<p>An insurer may not cancel or non-renew a Medicare supplement insurance policy or certificate for any reason other than nonpayment of premiums or material misrepresentation pursuant to Section 58.1(c)(1).</p> <p>An insurer shall not cancel or non-renew a Medicare supplement insurance policy or certificate on the ground of health status of the insured. Section 58.1(c)(2).</p> <p>No Medicare supplement insurance policy or certificate shall 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 nonpayment of premium. Section 58.1(c)(3).</p> <p>Termination of a Medicare supplement policy requires coverage of an injury that occurred while the policy was in force, but the extension of benefits beyond the period the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any or payment of the maximum benefits. If no specific benefit period is provided, an extended benefit period of at least 12 months must be included in the policy or certificate. Section 58.1(c)(8).</p>	
Suspension	11NYCRR58.1(c)(7)(i) 11NYCRR58.1(c)(7)(iii)	<p>Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder (up to 24 months) where he/she has applied for and is determined to be entitled to:</p> <p>(1) medical assistance under title XIX of the Social Security Act, if he/she notifies the issuer within 90 days after the date the individual becomes entitled to such assistance, or</p> <p>(2) benefits under 42 U.S.C. §426(b) and is covered under a group health plan.</p>	
Reinstitution of Coverage Following Suspension	11NYCRR58.1(c)(7)(iv)	<p>Reinstitution of coverage following suspension shall not contain a waiting period with respect to treatment of preexisting conditions, but shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension. Reinstitution shall also provide for the classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.</p>	
Renewal and Continuation	11NYCRR58.1(b)(1)(i)	<p>Medicare supplement policies must be "guaranteed renewable" and must comply with</p>	

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	11NYCRR58.1(b)(2)	Sections 58.1 (b)(1) and (2) of Regulation 193. Medicare supplement insurance policies and certificates shall include a renewal or continuation provision contained on the first page of the policy or certificate and shall include any reservation by the issuer of the right to change premiums. Section 58.1(b)(2).	
Replacement	11NYCRR58.1(d)(5) 11NYCRR58.1(d)(7)(ii)	Sale of Medicare supplement insurance is prohibited where an individual would have more than one Medicare supplement policy or certificate or would have duplicative benefits under a Medicare Advantage plan. Section 58.1(d)(5). The insured may switch to a different Medicare supplement policy offered by that insurer, but the insurer may limit the switch to once every 12 months or a date specific. Section 58.1(d)(7)(ii). The insured may switch to a new carrier at any time. Section 58.1(i).	
OPTIONAL STANDARD PROVISIONS		<i>These provisions MAY be included at the insurer's option.</i>	Form/Page/Para Reference
Change of Occupation	§3216(d)(2)(A)	If this provision is included, it must comply with the standard provision language of the statutory provision and may NOT be less favorable in any respect to the insured.	
Unpaid Premium	§3216(d)(2)(G)	If this provision is included, it must comply with the standard provision language of the statutory provision and may NOT be less favorable in any respect to the insured.	
Cancellation	§3216(d)(2)(H)	If this provision is included, it must comply with the standard provision language of the statutory provision and may NOT be less favorable in any respect to the insured.	
Conformity with State Statutes	§3216(d)(2)(I)	If this provision is included, it must comply with the standard provision language of the statutory provision and may NOT be less favorable in any respect to the insured.	
PERMISSIBLE EXCLUSIONS & LIMITATIONS			
Preexisting Conditions	11NYCRR58.1(a)(7)(i) 11NYCRR58.1(b)(3) 11NYCRR58.1(b)(4) 11NYCRR58.1(i)(4)	Preexisting conditions may not be excluded for a period in excess of 6 months from the effective date of coverage and the issuer shall credit the time the person was covered under creditable coverage, if the previous coverage was continuous to a date not more than 63 days prior to the enrollment date of the new coverage. The period of the preexisting condition limitation shall be reduced by the aggregate period of creditable coverage without regard to the benefits covered during the period. Section 58.1(b)(3). Except for the permissible preexisting condition limitations, no policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare. Section 58.1(b)(4). The issuer of a Medicare supplement insurance policy or certificate may not impose an exclusion of benefits based upon preexisting condition under such policy or certificate in the case of an individual described in 42 U.S.C. section 1395ss(s)(3)(B) or (F) who seeks to enroll under the Medicare supplement insurance policy or certificate during the period specified in 42 U.S.C. section 1395ss(s)(3)(E) and who submits evidence of the date of termination or disenrollment along with the application for such Medicare supplement insurance policy or certificate. Section 58.1(i)(4).	
Duplicative Benefits	11NYCRR58.1(b)(5)	No Medicare supplement insurance policy or certificate shall contain benefits that duplicate benefits provided by Medicare.	

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Indemnity	11NYCRR58.1(b)(6)	A Medicare supplement insurance policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.	
Payment of Benefits	11NYCRR58.1(b)(8)	Medicare supplement insurance shall not provide for the payment of benefits based on standards described as “usual and customary”, “reasonable and customary” or words of similar import.	
APPLICATIONS			Form/Page/Para Reference
Health Questions	11NYCRR58.1(d)(1)	Applications may not contain questions dealing with health or health history of the applicant and no physical examination may be requested.	
Multiple Policies	11NYCRR58.1(d)(2)	Applications must include a conspicuous bold face notice advising the applicant that the sale of Medicare supplement insurance is prohibited where an individual has a Medicare supplement insurance policy in force and is not seeking to replace the existing policy or where the Medicare supplement insurance policy would duplicate benefits for which the individual is entitled under a Medicare Advantage plan.	
Required Plans	11NYCRR58.1(d)(3)	All applications for Medicare supplement insurance must contain the right to apply for standardized Medicare supplement benefit plans “A” and “B” and “C” or “F”.	
Agent Statement	11NYCRR58.1(d)(4) 11NYCRR58.1(d)(7)	Agents, when recommending the purchase or replacement of any Medicare supplement insurance policy or certificate must make reasonable efforts to determine the appropriateness of the recommendation. An application taken by an agent must also include or have attached to it a statement to be signed by the agent as specified in Section 58.1(d)(4). On the application, the agent shall also list any other accident and health insurance policies he has sold to the applicant, listing all policies that are still in force and all policies sold in the last five years which are no longer in force. Section 58.1(d)(7).	
Replacement Questions	11NYCRR58.1(d)(6)	Applications must contain questions designed to elicit whether the applicant has a Medicare supplement plan, Medicare Advantage plan, Medicaid or another accident and health policy in force and whether the applied for plan is intended to replace the existing plan. Applications taken by an agent must be signed by the agent. Section 58.1(d)(6).	
Required Statements	11NYCRR58.1(d)(6)(i)	The following statements shall appear in the application as specified in Section 58.1(d)(6)(i): a. You do not need more than one Medicare supplement policy or certificate. b. If you purchase this policy (certificate), you may want to evaluate your existing health coverage and decide if you need multiple coverages. c. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. d. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy (certificate) may be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (certificate) (or, if that is no longer available, a substantially equivalent policy) will be reinstated if	

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		<p>requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.</p> <p>e. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.</p> <p>f. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the State Medicaid Program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB).</p>	
Required Questions	11NYCRR58.1(d)(6)(ii)	<p>The following questions shall be included in the application in accordance with Section 58.1(d)(6)(ii):</p> <p>[Please mark Yes or No below with an "X"]</p> <p>(a) (1) Did you turn age 65 in the last 6 months? Yes____ No____</p> <p>(2) Did you enroll in Medicare Part B in the last 6 months? Yes____ No____</p> <p>(3) If yes, what is the effective date? _____</p> <p>(b) Are you covered for medical assistance through the state Medicaid program?</p> <p>(NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)</p>	

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		<p>Yes___ No___</p> <p>If yes,</p> <p>(1) Will Medicaid pay your premiums for this Medicare supplement policy?</p> <p style="text-align: center;">Yes___ No___</p> <p>(2) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?</p> <p style="text-align: center;">Yes___ No___</p> <p>(c) (1) If you had coverage from any Medicare Advantage plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO, PPO or PFFS), fill in your start and end dates below. If you are still covered under this plan, leave "END DATE" blank.</p> <p style="text-align: center;">START DATE_____ END DATE_____</p> <p>(2) If you are still covered under the Medicare Advantage plan, do you intend to replace your current coverage with this new Medicare supplement policy?</p> <p style="text-align: center;">Yes___ No___</p> <p>(3) Was this your first time in this type of Medicare Advantage plan?</p> <p style="text-align: center;">Yes___ No___</p> <p>(4) Did you drop a Medicare supplement policy to enroll in the Medicare Advantage plan?</p> <p style="text-align: center;">Yes___ No___</p> <p>(d) (1) Do you have another Medicare supplement or Medicare Select policy or certificate in force?</p> <p style="text-align: center;">Yes___ No___</p> <p>(2) If so, with what company, and what plan do you have?</p> <p style="text-align: center;">_____</p> <p>(3) If so, do you intend to replace your current Medicare supplement or Medicare Select policy or certificate with this policy?</p>	
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		<p style="text-align: center;">Yes____ No____</p> <p>(e) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)</p> <p style="text-align: center;">Yes____ No____</p> <p>(1) If so, with what company and what kind of policy?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>(2) What are your dates of coverage under the other policy?</p> <p style="text-align: center;">START DATE_____ END DATE_____</p> <p style="text-align: center;">(If you are still covered under the other policy, leave "END DATE" blank.)</p>	
Copy of Application	11NYCRR58.1(d)(8)	Where the applicant applies directly to the issuer, a copy of the application, signed by the applicant and acknowledged by the issuer, is to be returned to the applicant upon the delivery of the policy (certificate).	
Telephone or In-Person Interview	§3204 Article III, NY Technology Law	<p>If a telephone or in-person interview will be used with this application, the interview is conducted in the following manner:</p> <p>a. Any questions raised during the interview are limited to those questions appearing on an application approved by the Department (i.e., questions over the phone would be no different than those being asked in the application).</p> <p>b. The applicant must be provided with a written copy and will have an opportunity to review and make corrections to those statements that were attributed to him/her in the interview.</p> <p>c. Any information obtained in the interview that will be used in the underwriting process will be reduced to writing, signed by the applicant and attached to the policy in compliance with §3204.</p> <p>d. If an electronic signature is used, it must comply with the Electronic Signatures and Records Act (Article III of the New York Technology Law).</p> <p>e. If a telephonic application is being used, please provide a description of the procedure for taking a telephonic application. Any scripts used in the telephone interview must be filed for reference.</p>	
Credit for Previous	11NYCRR58.1(d)(9)	The application must include a question designed to elicit information that is sufficient to allow	

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Coverage		the issuer to determine whether the applicant is eligible for a credit for previous coverage as provided in Section 58.1(d)(9), where the policy or certificate includes a preexisting conditions limitation.	
Solicitation of Applications	11NYCRR58.1(d)(10)	An issuer may not solicit coverage or accept applications, for individuals who are eligible for Medicare by reason of age, more than 90 days prior to the month in which an individual has his 65 th birthday.	
Investigative Consumer Report	§380-c of the General Business Law	If an Investigative Consumer Report will be prepared or procured, the insurer complies with Section 380-c of the General Business Law by providing notice in the application or in a separate form.	
Authorization	11NYCRR420.18(b)	Section 420.18(b) of Regulation 169 requires that an authorization to disclose nonpublic personal health information specify the length of time the authorization will remain valid (maximum 24 months).	
Fraud Warning	§403(d)	Section 403(d) of the Insurance Law requires a fraud warning on the application form.	
CONDITIONAL RECEIPTS/ INTERIM INSURANCE AGREEMENTS			
Requirement	11NYCRR52.53	Section 52.53 of Regulation 62 requires that, if premium is paid prior to policy delivery and the insurer requires a determination of insurability as a condition precedent to the issuance of a policy, an insurer must issue either a conditional receipt or interim insurance agreement. In general, Section 52.53 sets forth two permissible methods for money to be accepted with an application – conditional receipt or interim insurance agreement. Section 52.53(c) defines a “determination of insurability” as a determination by the insurer as to whether the proposed insured is insurable under its underwriting rules and practices for the plan and amount of insurance applied for and at the insurer’s standard premium rate. As Medicare supplement insurance is open-enrolled and community-rated, the determination would be whether the applicant was enrolled in both Parts A and B of Medicare, or whether the applicant has other Medicare Supplement insurance or Medicare Advantage coverage and if he/she intends to replace it.	
Effective Date	11NYCRR52.53(a)	<p>A conditional receipt sets an effective date for the policy once the company determines if the applicant is eligible for a Medicare supplement insurance policy/certificate. The conditional receipt shall contain an agreement to provide coverage subject to any reasonable limit regarding the amount of insurance specified in the receipt, contingent upon insurability, and provides that such insurability be determined as of a date no later than:</p> <p style="text-align: center;">The date of completion of all parts of the application, AND</p> <p style="text-align: center;">The required premium has been paid.</p> <p>If the proposed insured is insurable as of the above date, coverage under the issued policy begins not later than such date, except as provided in Section 52.53(f).</p>	
Insurability	11NYCRR52.53(e) 11NYCRR52.53(b)	If the applicant is not Medicare eligible or is otherwise uninsurable for the insurance plan for which application was made after the date provided in Section 52.53(a) but before the application is approved or rejected and before the expiration of any time limit specified in the	

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		<p>receipt, an insurer may determine that the proposed insured is not insurable only as of the date stated in Section 52.53(a). Note that a determination of insurability may not be based on health status.</p> <p>An interim insurance agreement provides some type of immediate limited insurance coverage as of the application date. The agreement provides coverage in accordance with the policy and plan of insurance described in the application subject to any reasonable limit regarding the amount or duration of insurance specified in the agreement. Coverage is provided as of the application date and must provide at least 60 days coverage unless:</p> <ol style="list-style-type: none"> a. The policy applied for is issued prior to the end of the 60 days, OR b. The applicant receives actual notice that coverage under the agreement is cancelled because the application has been declined. If notice is given by mail, it may be deemed received on the fifth day after mailing such notice to the applicant. Section 52.53(b) of Regulation 62. 	
Specified Date	11NYCRR52.53(f)	An insurer may honor a written request from the applicant that coverage begins as of a specified date later than the date provided for in the conditional receipt or interim insurance agreement. In other than replacement situations, the applicant's written request for a later effective date must contain a statement signed by the applicant that he/she understands that he/she may be waiving certain rights and guarantees under the conditional receipt or interim insurance agreement.	
Multiple Insureds	11NYCRR52.53(d)	If coverage is provided under a conditional receipt or interim insurance agreement for two or more proposed insureds, the coverage must be determined separately for each proposed insured, except, however, all proposed insureds may be rejected in the event of fraud or material misrepresentations.	
Time limit	11NYCRR52.53(f)	If a policy is not issued within the time specified in the conditional receipt or interim insurance agreement, the application will be deemed rejected and all premiums will be refunded.	
Mail Order Cases	11NYCRR52.53(g)	In mail order cases only, an insurer may postpone the effective date of coverage to the date of issuance of the policy.	
OTHER DOCUMENTS TO BE FILED WITH POLICY FORMS			Form/Page/Para Reference
Outline of Coverage	11NYCRR58.5(a), (b), (d) & (e) 11NYCRR58.5(c)	The disclosure 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. All benefit plans shall be shown on the cover page and the plans offered by the issuer shall be prominently identified with no more than four (4) plans on each chart. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be	

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		<p>illustrated. Section 58.5(a), (b), (d) & (e)..</p> <p>The disclosure statement must be provided to the applicant at the time the application is presented to the prospective applicant. Section 58.5(c).</p>	
Replacement Notice	<p>11NYCRR58.1(e)(1) 11NYCRR58.1(e)(2)</p>	<p>Upon the determination that the sale of a Medicare supplement insurance or Medicare Select policy or certificate will involve replacement of accident and health insurance, the issuer or agent, unless it is a direct response issuer, shall furnish the applicant, prior to the issuance or delivery of the policy or certificate, a notice regarding replacement of coverage. A direct response issuer shall deliver the replacement notice at the time of issuance of the policy. The issuer/agent and the applicant must sign two copies of the replacement notice. One copy is to be provided to the applicant. The second copy is to be retained by the issuer. Section 58.1(e)(1).</p> <p>The notice shall be in no less than 12-point type and shall appear in substantially the same format as follows (Section 58.1(e)(2)):</p> <p style="text-align: center;">NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE, HMO COVERAGE OR EMPLOYER-PROVIDED HEALTH BENEFIT ARRANGEMENT</p> <p style="text-align: center;">(Insurance Company's Name and Address)</p> <p style="text-align: center;">SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.</p> <p>According to (your application) (information you have furnished), you intend to terminate existing accident and health insurance, health maintenance organization coverage or employer-provided health benefit coverage and replace it with a policy (certificate) to be issued by (Company Name) Insurance Company. Your new policy (certificate) will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy (certificate).</p> <p>You should review this new coverage carefully. Compare it with all health coverage you now have and evaluate the need for existing coverage that may duplicate this policy (certificate). Terminate your present coverage only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.</p> <p style="text-align: center;">STATEMENT TO APPLICANT BY ISSUER, AGENT (BROKER OR OTHER REPRESENTATIVE):</p> <p>I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction (does) (does not) duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s) checked below:</p> <p style="margin-left: 40px;">___ Additional benefits ___ No change in benefits, but lower premiums</p>	

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		<p> <input type="checkbox"/> Fewer benefits and lower premiums <input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D. <input type="checkbox"/> Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. _____ <input type="checkbox"/> Other (please specify) _____ _____ </p> <p>1. Health conditions that you may presently have may be considered preexisting conditions and may not be immediately or fully covered under the new policy (certificate). This could result in denial or delay of a claim for benefits under the new policy (certificate), whereas a similar claim might have been payable under your present coverage. (This paragraph may be deleted if the replacement does not involve application of a new preexisting condition limitation).</p> <p>2. State regulation provides that in applying a preexisting condition limitation, a Medicare supplement issuer must credit the time the applicant was previously covered under creditable coverage (including Medicare supplement insurance, Medicare select coverage, and Medicare Advantage plans) if the previous creditable coverage was continuous to a date not more than 63 days prior to the enrollment date of the new policy or certificate. (This paragraph may be deleted if the replacement does not involve application of a new preexisting condition limitation).</p> <p>3. If you still wish to terminate your present policy or certificate and replace it with new coverage, review the application carefully before you sign it to be certain that all information has been properly recorded.</p> <p>Do not cancel your present coverage until you have received your new policy (certificate) and are sure that you want to keep it.</p> <p style="text-align: center;">_____ Signature of Agent, Broker, or other Representative (Signature not required for direct response sales.)</p> <p style="text-align: center;">(Insert typed name of and address of issuer, agent or broker)</p> <p style="text-align: center;">_____ (Applicant's signature)</p> <p style="text-align: center;">_____ (Date)</p>	
<p>Second Replacement Notice</p>	<p>11NYCRR58.1(e)(3)</p>	<p>A second type of replacement notice is required to either be delivered with the first premium due notice mailed to the policyholder or certificate holder after the replacement coverage is issued or sent separately within 30 days of the date of the first premium due notice, but in no event shall such notice be provided later than 6 months after the issuance of the replacement policy or certificate. The second notice is required if a Medicare supplement or Medicare select policy or certificate replaces another Medicare supplement or Medicare select policy or certificate or a Medicare Advantage plan or a policy or certificate issued pursuant to a contract under section 1876 of the Federal Social Security Act, then the replacing issuer must provide the policyholder or certificate holder with the following written notice:</p>	

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		<p>“Your application for the Medicare supplement insurance Policy (certificate) issued by this company indicates that you intend to terminate existing Medicare supplement insurance coverage, Medicare select coverage, Medicare Advantage plan or health maintenance organization (HMO) issued Medicare cost contract and replace it with the coverage applied for with this company. Duplicate coverage is unnecessary and you should terminate one of your existing coverages if more than one plan is still in force.”</p>	
DISCONTINUANCE			
Notice	11NYCRR58.1(l)(4)(ii)(a)	An issuer must give at least 30 days written notice to the superintendent prior to discontinuing the availability of the form of the policy or certificate. The issuer may not offer to sell the policy form or certificate form after the superintendent receives the notice.	
Period of Discontinuance	11NYCRR58.1(l)(4)(ii)(b)	An issuer that discontinues the availability of the policy or certificate form shall not file for approval a new policy or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the superintendent of the discontinuance.	
Sale or Transfer of Business	11NYCRR58.1(l)(4)(iii)	In accordance with Section 58.1(l)(4)(ii)(b), the transfer or sale of Medicare supplement business is considered a discontinuance.	
Change in Rating Structure or Methodology	11NYCRR58.1(l)(4)(iv)	<p>In accordance with Section 58.1(l)(4)(iv), a change in the rating structure or methodology shall be considered a discontinuance unless the issuer:</p> <ol style="list-style-type: none"> a. provides an actuarial memorandum describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates; and b. does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. 	
NEW PRODUCTS – RATE REQUIREMENTS		<p style="text-align: center;">(For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below instead.)</p> <p><i>Complete this section for all forms filings except those filings where a rate filing is unnecessary because: (select one)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> <i>The submission contains only application forms, disclosure statements, and/or advertising, OR</i> <input type="checkbox"/> <i>The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR</i> <input type="checkbox"/> <i>The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.</i> 	Form/Page/Para Reference
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	<p>Actuarial qualifications:</p> <ol style="list-style-type: none"> a. Member of the Society of Actuaries; and 	

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		b. Meet the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.	
Justification of Rates	11NYCRR52.40(d)(1) and 52.40(k) 11NYCRR52.45(i)(2)	a. Specific formulas and assumptions used in calculating rates b. Expected claim costs c. Actuarial justification for the use of claim costs and other assumptions d. Description of marketing methods e. Basis for the application of geographically varying premiums f. Non-claim expense components as a percentage of gross premium g. Expected loss ratios by duration and in the aggregate	
Loss Ratios	11NYCRR52.40(d)(1)(ix) and (x) 11NYCRR52.45(i)(2)	Expected loss ratios by duration and in the aggregate – with actuarial justification	
Actuarial Certification	11NYCRR52.40(a)(1)	a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans” as adopted by the Actuarial Standards Board. c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory.	
Expected Loss Ratio Certification		The expected loss ratio is: <input type="text"/> %	
ACTIVE RATE MANUAL	11NYCRR52.40(c)(2)	a. Table of Contents b. Insurer name on each consecutively numbered rate page c. Identification by form number of each policy, rider, or endorsement to which the rates apply d. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits e. Description of rating classes and premium discounts, including description of any geographic rating areas, statement that premiums will be charged based on current residence within New York State, and the rating practice used in the event of residence change to an area outside of New York State. f. Examples of rate calculations g. Commission schedule(s), including statement that commission amounts will not vary by age	

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		<p>of the applicant.</p> <p>h. Underwriting guidelines and/or underwriting manual</p> <p>i. Expected loss ratios</p>	
EXISTING PRODUCTS – RATE REQUIREMENTS		<p>(For new products, do NOT complete this section – complete the New Products-Rate Requirements section above instead.)</p> <p><i>Complete this section for all filings of changes in rates except annual experience/rate adjustment filings (e.g., changes in rate calculation rules or procedures), commissions or underwriting to existing products.</i></p>	Form/Page/Para Reference
ACTUARIAL MEMORANDUM	11NYCRR52.40(a)(1)	<p>Actuarial qualifications:</p> <p>a. Member of the Society of Actuaries; and</p> <p>b. Meet the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.</p>	
Justification of Rates	11NYCRR52.40(d)(2) or 52.40 (d) (3) and 52.40(k) 11NYCRR52.45(i)(2)	<p>a. Description of proposed commission schedule</p> <p>b. Description of proposed change in geographic classifications</p> <p>c. Description of benefits that result in a change in rates</p> <p>d. History of previous New York rate revisions</p> <p>e. Provide New York and nationwide claims experience since inception respectively, including:</p> <ul style="list-style-type: none"> (i) Earned premium (ii) Paid and incurred claims (iii) Incurred loss ratios <p>f. Provide New York and nationwide claims experience since inception with premiums adjusted to a single rate basis</p> <p>g. First and last years of issue</p> <p>h. Derivation of proposed rate revision in detail with actuarial justification</p> <p>i. Non-claim expense components as a percentage of gross premium</p> <p>j. Expected loss-ratios –by duration and aggregate</p>	

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		k. Impact on rates due to changes with actuarial justification	
Actuarial Certification	11NYCRR52.40(a)(1)	<p>a. The filing is in compliance with all applicable laws and regulations of the State of New York.</p> <p>b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans”.</p> <p>c. The expected loss ratio meets the minimum requirements of the State of New York.</p> <p>d. The benefits are reasonable in relation to the premiums charged.</p> <p>e. The rates are not unfairly discriminatory.</p>	
Expected Loss Ratio Certification		The expected loss ratio is: %.	
REVISED RATE MANUAL PAGES	11NYCRR52.40(a)(3) and 52.40(c)	<p>a. Revised numbered rate manual pages reflecting the change being requested for either the Active Rate Manual or the Inactive Rate Manual, depending on whether or not the policy form is still sold in New York.</p> <p>b. Specific reference to sections, pages, and edition dates of rate pages revised.</p>	
ADVERTISING AND MARKETING			Form/Page/Para Reference
Prior review	11NYCRR215.5(d) 11NYCRR58.1(b)(9)	All advertisements must be submitted to the Department for review and filing prior to use.	
Marketing Procedures	11NYCRR58.1(g)(1)	Issuers are required to establish marketing procedures to: assure the fair and accurate comparison of policies by its agents, assure excessive insurance is not sold or issued, make every reasonable effort to identify whether a prospective applicant already has accident and health insurance and the types and amounts of that insurance, and establish auditable procedures for verifying compliance with regulatory marketing procedures.	
Prohibited Acts & Practices	11NYCRR58.1(g)(2)	<p>Issuers are prohibited from knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.</p> <p>Advertisements may not have the effect or tend to induce the purchase of insurance through force, fright, threat whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.</p> <p>Advertisements must clearly disclose that the intent of the advertisement is solicitation of insurance.</p>	
Form & Content	11NYCRR215.5(a)	The format and content of an advertisement must be complete and clear to avoid deception or the capacity or tendency to mislead or deceive.	
Statements Required	11NYCRR215.5(c)(8)	All advertisements must prominently display the statement that appears in Section 215.5(c)(8).	
Content	11NYCRR215.5(b)	Advertisements must be truthful and not misleading in fact or in implication.	

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Advertisement of Benefits Payable, Losses Covered or Premiums	11NYCRR215.6	Advertisements that include benefits payable, losses covered or premium amounts must be in compliance with Section 215.6.
Policy Provisions	11NYCRR215.7	Reference to dollar amounts, time periods for which benefits are payable, cost of a policy, policy benefits or the loss for which such benefit is payable, requires disclosure of provisions relating to renewability, cancellability and termination/modification of benefits, losses covered or premiums because of age, etc..., in a way as not to minimize qualifying conditions.
Testimonials & Endorsements	11NYCRR215.8	The use of testimonials and endorsements within advertising materials must be in compliance with Section 215.8.
Use of Statistics	11NYCRR215.9	The use of statistics within advertising materials must be in compliance with Section 215.9
Web-Based Advertising	11NYCRR215.5(d) 11 NYCRR 58.1(b)(9)	<p>Web-based material is considered advertising if it otherwise meets the definition of advertising in 11 NYCRR 215.3.</p> <p>Each webpage advertisement must be submitted for filing as a separate form with a unique form number in the lower left hand corner.</p> <p>Webpages submitted for filing should include all content on the page, as seen and in the format viewed online (not just the body of the page).</p> <p>Every webpage referenced by web address or hyperlink within a submitted form must be fully described in the 'Links/Descriptions' portion of the Explanation of Variability document (See 'Use of Internet Links' below).</p>
Use of Internet Links	11NYCRR215.5(d)	For all filings containing advertisements* that list URLs or use hyperlinks to navigate directly to other advertising content, a 'Links/Descriptions' supporting document must be included. The 'Links/Descriptions' supporting document must indicate when the content in question was filed, the form number, and the state tracking number. Please include the 'Links/Descriptions' supporting document on a separate page in the Explanation of Variability document. The 'Links/Descriptions' document should contain the same form number in the bottom left hand corner as the Explanation of Variability. (*See 11 NYCRR 215.3 for the definition of advertisement).
Identification of Plan or Policy	11NYCRR215.10	<p>Advertisements that refer to a choice of benefits must disclose that benefits provided depend upon the plan selected and that premiums may vary.</p> <p>Advertisements that refer to various benefits contained in multiple policies, other than group/blanket, must disclose that such benefits are provided only through a combination of such policies.</p>
Disparaging Statements	11NYCRR215.11	Advertisements shall not include unfair/incomplete comparisons of policies or benefits or include comparisons of non-comparable policies and must not disparage other competitors policies, services or business methods.
Government Endorsement	11NYCRR215.12	An advertisement shall not create an impression that it is approved, endorsed or accredited by New York or the Federal government.
Identity of Insurer	11NYCRR215.13	The actual insurer and form number(s) must be identified in all advertisements.

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		Advertisements must not include words, symbols or physical materials which are similar to that used by agencies of the Federal government or New York that tend to confuse or mislead consumers that it is connected with an agency of the municipal, State or Federal government.	
Introductory, Initial or Special Offers	11NYCRR215.15	Advertisements shall not imply that they are introductory, initial or special offers and shall be in full compliance with Section 215.15.	
Statements about Insurer	11NYCRR215.16	Statements about an insurer must clearly indicate the purpose of the recommendation and the limitation of the scope and extent of the recommendation.	
Full Review	11NYCRR215	A full review of each advertisement should be undertaken for compliance with Section 215 prior to filing with this Department.	
Filing & Approval	11NYCRR58.1(l)(4)(i)	Following the approval of forms for an issuer new to the Medicare supplement insurance market, the Department must be notified of the issuer's intent to market the forms a minimum of 15 days prior to the issuer's sale of the product.	