Links to applicable rules and statutes: [**Ins 400 - Submission/Form Rules**](http://www.gencourt.state.nh.us/rules/state_agencies/ins400.html)**;** [**415-F**](http://www.gencourt.state.nh.us/rsa/html/XXXVII/415-F/415-F-mrg.htm)**;** [**Ins 1900**](http://www.gencourt.state.nh.us/rules/state_agencies/ins1900.html)**;** [**Ins 2600**](http://www.gencourt.state.nh.us/rules/state_agencies/ins2600.html)**.**

**THIS CHECKLIST DOES NOT APPLY TO GROUP MEDICAL SUPPLEMENTAL POLICIES ISSUED TO EMPLOYERS OR LABOR ORGANZIATIONS, OR TRUSTEES OF FUNDS ESTABLISHED FOR SAME, THAT ARE EXEMPT UNDER RSA 415-F:2.**

**CARRIERS SEEKING APPROVAL OF MEDICARE SUPPLEMENT POLICIES THAT ARE EXEMPT FROM RSA 415-F:2 MUST SUBMIT THE LIMITED BENEFIT COVERAGE CHECKLIST.**

I. SUBMISSION REQUIREMENTS – ALL FORMS

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| --- | --- | --- | --- | --- |
|  | RULE/STATUTE REFERENCE | CONFIRM SUBMISSION ADHERES TO THE FOLLOWING REQUIREMENTS | YES | N/A |
| Filing Submission Requirements | Ins 401.14 (c) | Third Party Authorization: Authorization letter is attached to the Supporting Documentation tab if the forms are being submitted on behalf of an insurance company.  |  |  |
|  | Ins 401.14 (e) | Certificate of Compliance is signed/dated and attached to the Supporting Documentation tab. |  |  |
|  | RSA 420-H:5 I (a) & IV | All policy, certificate, or contract forms have a minimum Flesch score of 40. Certification of the Flesch score is attached to the Supporting Documentation tab or Readability Scores are completed on the Form Schedule tab.  |  |  |
|  | Ins 401.14 (f) | The SERFF Filing Description includes a brief description of each form, including any new or unusual features, and a list of forms to which it will be attached. |  |  |
|  |  | The General Information tab indicates a brief statement indicating the filing status in the state of domicile, including the date approved. |  |  |
|  |  | The SERFF Filing Description includes a statement indicating if a form is replacing another form, including the name of the form being replaced. |  |  |
|  |  | (4) If a form is being replaced, a “red-lined” document indicating the differences between the previous and new forms is attached to the Supporting Documentation tab. |  |  |
|  | Ins 401.14 (o) | If a rider, amendment, or endorsement is filed that changes or adds language to another form(s), a “red-lined” document of the impacted form highlighting the changes is attached to the Supporting Documentation tab. |  |  |
| Form Submission Requirements | Ins 401.14 (g) | All forms are submitted in the same layout as sold to consumers in New Hampshire.  |  |  |
|  | Ins 401.14 (h) | All policy, certificate, and contract forms over 3,000 words or printed on 3 or more pages are electronically bookmarked with a Table of Contents or index of the principal sections of the form. |  |  |
|  | Ins 401.14 (i) | Specifications page is completed with hypothetical data that is realistic and consistent with the other contents of the policy/contract. |  |  |
|  | Ins 401.14 (k) | All forms are filed as intended for use with all related forms to enable the review of the form with proper context. |  |  |
|  | Ins 401.14 (l) | Certificates include enrollment forms. |  |  |
|  | Ins 401.14 (m) | Policies, certificates, and rates are submitted together. |  |  |
|  | Ins 401.14 (p) | All variable language is identified with the use of brackets and a statement of variability is attached to the Supporting Documentation tab. |  |  |
|  | Ins 401.14 (q) | Revised forms are submitted with a distinguishing form number. |  |  |
|  | Ins 401.14 (r) | All forms submitted are in final print. |  |  |
|  | Ins 401.14 (u) | If a Group policy or certificate is filed, the corresponding group certificate or policy is included on the same filing.  |  |  |
|  | Ins 401.14 (w) | If forms were previously disapproved and are being resubmitted for review, the previous SERFF tracking number is stated in the Filing Description. In addition, all previous correspondence and red-lined copies of the previously submitted forms are attached to Supporting Documentation tab in SERFF.  |  |  |

II. GENERAL FORM REQUIREMENTS

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| --- | --- | --- | --- | --- |
|  | RULE/STATUTE REFERENCE | CONFIRM FORMS ADHERE TO THE FOLLOWING REQUIREMENTS | YES | N/A |
| Policy number | Ins 401.04 (a) | Each form shall contain a form number containing numbers, letters, or both that shall be placed in the lower left corner. The form number may contain the prefix “Form”. If a change is made to the form, the new form shall be submitted with a new form number. |  |  |
| Corporate Information | Ins 401.04 (b) | Each policy and certificate shall contain the full corporate title, address, toll free telephone and facsimile numbers, and the company website address if available. |  |  |
| Brief Description | Ins 401.04 (c) | Each policy and certificate shall provide a brief description of the nature of the policy on the face page, specifications page, or back page. |  |  |

III. GENERAL APPLICATION/ENROLLMENT FORM REQUIREMENTS

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| --- | --- | --- | --- | --- |
|  | RULE/STATUTE REFERENCE | CONFIRM APPLICATIONS/ENROLLMENT FORMS ADHERE TO THE FOLLOWING REQUIREMENTS | YES | N/A |
| Application - Declarative statement | Ins 401.12 (a) | The declarative portion of the application, if any, shall imply a representation of facts to the best of the applicant's knowledge. For example "I represent," or "To the best of my knowledge and belief, Wording such as "I Certify" are prohibited. |  |  |
| Application - Medical Questions | Ins 401.12 (c) | Medical questions of a technical nature beyond the capability of the average applicant, such as a detailed gastrointestinal questionnaire, shall be prohibited. |  |  |
| Application - Prohibition | Ins 401.12 (d) | No provision is permitted that changes the terms of the policy to which it is attached. |  |  |
| Application - Prohibition | Ins 401.12 (e) | Questions as to race or ethnicity are prohibited. |  |  |
| Application-Replacement | Ins 401.12 (f) | All applications shall contain a question inquiring whether the policy sought is intended to replace an existing policy; |  |  |
| Applications - Required Questions | Ins 1905.20 | (a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used. 1) [Statements]: 2) [Questions]: (b) Agents shall list any other health insurance policies they have sold to the applicant. (1) List policies sold which are still in force. (2) List policies sold in the past 5 years that are no longer in force.(c) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy. (d) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant, and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage. |  |  |
| Applications - Replacement Notice | Ins 1905.20 (e) | (e) The notice required by 1905.20 (d). above for an issuer shall be provided in substantially the following form in no less than 12-point type. NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE[Insurance company's name and address]SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]: I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one): \_\_\_\_ Additional benefits. \_\_\_\_ No change in benefits, but lower premiums. \_\_\_\_ Fewer benefits and lower premiums. \_\_\_\_ My plan has outpatient prescription drug coverage and I am enrolling in Part D. \_\_\_\_ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. [Optional only for Direct Mailers.] \_\_\_\_\_\_\_\_\_ \_\_\_ Other. (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_Note: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy. 2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy. 3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history.Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.] Do not cancel your present policy until you have received your new policy and are sure that you want to keep it. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Signature of Agent, Broker or Other Representative)\* [Typed Name and Address of Issuer, Agent or Broker] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Applicant's Signature) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Date) \*Signature not required for direct response sales. (f) Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation. |  |  |
| Prohibition Against use of Genetic Information | Ins 1905.26 | Prohibition Against Use of Genetic Information and Requests for Genetic Testing (GINA) |  |  |
| Applications - Underwriting Questions - Open Enrollment and Guaranteed Issue Periods | Ins 1905.13 | Underwriting questions, including tobacco use, height and weight, are prohibited for Open Enrollment and Guaranteed Issue. Ins 1905.13 Open Enrollment. (a)An issuer 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 a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the 6 month period beginning with the first day of the first month in which an individual is enrolled for benefits under Medicare Part B and when each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age. |  |  |
| Guaranteed Issue for Eligible Persons | Ins 1905.14 | Ins 1905.14 Guaranteed Issue for Eligible Persons. (a) Guaranteed issue shall be for: (1) Eligible persons are those individuals described in (b) who: a. Seek to enroll under the policy during the period specified in Ins 1905.13(c), and who b. Submit evidence of the date of termination or disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy. (2) With respect to eligible persons, an issuer shall not: a. Deny or condition the issuance or effectiveness of a Medicare supplement policy described below that is offered and is available for issuance to new enrollees by the issuer; b. Discriminate in the pricing of such a Medicare supplement policy because of: (i) Health status; (ii) Claims experience; (iii) Receipt of health care; or (iv) Medical condition; and c. Impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy. |  |  |

IV. GENERAL MEDICARE SUPPLEMENT REQUIREMENTS

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|  | RULE/STATUTE REFERENCE | CONFIRM FORMS ADHERE TO THE FOLLOWING REQUIREMENTS | YES | N/A |
| Definitions: General | RSA 415-F:1 and Ins 1905.03 |  |  |  |
| Definition: Policy | Ins 1905.04 |  |  |  |
| Policy/Certificate Form |  |  |  |  |
| Cover Page: Renewal or Continuation | Ins 1905.19 (a) (1) | (1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age. |  |  |
| Cover Page: Free Look | Ins 1905.19 (a) (5) | (5) 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 and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason. |  |  |
| Cover Page: Notice to Buyer | Ins 1905.22 (a) (3) | (3) Display prominently by type, stamp or other appropriate means, on the first page of the policy the following: "Notice to buyer: This policy may not cover all of your medical expenses." |  |  |
| General Provisions | Ins 1905.05 | (a) Except for permitted preexisting condition clauses as described in Ins 1905.06 (b)(1) and (2), Ins 1905.07 (b)(1) and Ins 1905.08 (a)(1) of this rule, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare. (b) No Medicare supplement policy or certificate shall use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions. (c) No Medicare supplement policy or certificate in force in the state shall contain benefits that duplicate benefits provided by Medicare. (d) Subject to Ins 1905.06 (b)(5), (6) and (8), and Ins 1905.07 (b)(4) and (5), a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder. (e) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005. |  |  |
| General Provisions | Ins 1905.19 (a) (3) | (3) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import. |  |  |
| Benefit Standards (effective 06/01/2010)Pre-Existing ConditionsParity of Sickness and AccidentsBenefits to change with Medicare cost-sharingNo automatic termination of spouse coverage.Guaranteed RenewableGroup Conversion CoverageGroup Replacement CoverageExtension of Benefits due to Total DisabilitySuspension of Policy due to Medicaid, 24 months | Ins 1905.08 (a) | (a) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this part. (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. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage. (2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents. (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.(4) No Medicare supplement 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 the nonpayment of premium. (5) Each Medicare supplement policy shall be guaranteed renewable. a. The issuer shall not cancel or non-renew the policy solely on the ground of health status of the individual. b. The issuer shall not cancel or non-renew the policy for any reason other than nonpayment of premium or material misrepresentation. c. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Ins 1905.08 (5)(e), the issuer shall offer certificate holders an individual Medicare supplement policy which, at the option of the certificate holder: 1. Provides for continuation of the benefits contained in the group policy; or 2. Provides for benefits that otherwise meet the requirements of this subsection.d. If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall: 1. Offer the certificate holder the conversion opportunity described in Ins 1905.08 (a)(5)c.; or 2. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy. e. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced. (6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned 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. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.(7) a. A 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 for the period, not to exceed 24 months, in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to assistance. b. If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted, effective as of the date of termination of entitlement, as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.c. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended, for any period that may be provided by federal regulation, at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan, as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted, effective as of the date of loss of coverage, if the policyholder provides notice of loss of coverage within 90 days after the date of loss. |  |  |
| Reinstitution of Coverage due to termination of Medicaid | Ins 1905.08 (a) (7) d. | d. Reinstitution of coverages as described in subparagraphs b. and c above: 1. Shall not provide for any waiting period with respect to treatment of preexisting conditions; 2. Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and 3. Shall provide for 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. |  |  |
| Standards for Core Benefits | Ins 1905.08 (b) | (b) Standards for Basic Core Benefits Common to Medicare Supplement Insurance Benefit Plans A, B, C, D, E, F with High Deductible, G, M and N. Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu of it. (1) 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; (2) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used; (3) 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;(4) Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under federal regulations, unless replaced in accordance with federal regulations; (5) 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; (6) Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses. |  |  |
| Standards for Additional Benefits | Ins 1905.08 (c) | (c) Standards for Additional Benefits. The following additional benefits shall be included in Medicare supplement benefit plans B, C, D, E, F with High Deductible, G, M and N as provided by Ins 1905.10. (1) Medicare Part A Deductible: Coverage for 100% of the Medicare Part A inpatient hospital deductible amount per benefit period; (2) Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period; (3) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A; (4) Medicare Part B Deductible: Coverage for 100% of the Medicare Part B deductible amount per calendar year regardless of hospital confinement. (5) One hundred percent of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.(6) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80% 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 60 consecutive days of each trip outside the United States, subject to calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset. |  |  |
| Standardized Plan Designs (effective 6/1/2010) | Ins 1905.10 | (a)(1) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic core benefits, as defined in Ins 1905.08 (b). (2) If an issuer makes available any of the additional benefits described in Ins 1905.08 (c) or offers standardized benefit plans “K” or “L”, as described in Ins 1905.10 (e)(8) and (9), then the issuer shall make available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic core benefits as described in Ins 1905.10 (a)(1) above, a policy form or certificate form containing either standardized benefit plan “C”, as described in Ins 1905.10 (e)(3) or standardized benefit plan “F”, as described in Ins 1905.10 (e)(5). (b) No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Ins 1905.10 (f) and Ins 1905.11.(c) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this subsection and conform to the definitions in Ins 1905.03. Each benefit shall be structured in accordance with the format provided in Ins 1905.08 (b); or, in the case of plans “K” or “L”, in Ins 1905.10 (e)(8) or (9) and list the benefits in the order shown. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit. |  |  |
| Plan A |  | (e) Make-up of 2010 Standardized Benefit Plans: (1) Standardized Medicare supplement benefit plan “A” shall include only the following: a. The basic core benefits as defined in Ins 1905.08 (b). |  |  |
| Plan B |  | (e) (2) Standardized Medicare supplement benefit plan “B” shall include only the following: a. The basic core benefit as defined in Ins 1905.08 (b); plus b. One hundred percent of the Medicare Part A deductible as defined in Ins 1905.08 (c)(1). |  |  |
| Plan C |  | (e) (3) Standardized Medicare supplement benefit plan “C” shall include only the following: a. The basic core benefit as defined in Ins 1905.08 (b); plus b. One hundred percent of the Medicare Part A deductible as defined in Ins 1905.08 (c)(1); c. Skilled nursing facility care as defined in Ins 1905.08 (c)(3); d. One hundred percent of the Medicare Part B deductible as defined in Ins 1905.08 (c)(4); and e. Medically necessary emergency care in a foreign country as defined in Ins 1905.08 (c)(6). |  |  |
| Plan D |  | (e) (4) Standardized Medicare supplement benefit plan “D” shall include only the following: a. The basic core benefit as defined in Ins 1905.08 (b); plus b. One hundred percent of the Medicare Part A deductible as defined in Ins 1905.08 (c)(1); c. Skilled nursing facility care as defined in Ins 1905.08 (c)(3); and d. Medically necessary emergency care in a foreign country as defined in Ins 1905.08 (c)(6). |  |  |
| Plan F |  | (e) (5) Standardized Medicare supplement (regular) plan “F” shall include only the following: a. The basic core benefit as defined in Ins 1905.08 (b); plus b. One hundred percent of the Medicare Part A deductible as defined in Ins 1905.08 (c)(1); c. The skilled nursing facility care as defined in Ins 1905.08 (c)(3); d. One hundred percent of the Medicare Part B deductible as defined in Ins 1905.08 (c)(4); e. One hundred percent of the Medicare Part B excess charges as defined in Ins 1905.08 (c)(5); and f. Medically necessary care in a foreign country as defined in Ins 1905.08 (c)(6). |  |  |
| High Deductible Plan F |  | (e) (6) Standardized Medicare supplement plan “F” with high deductible shall include only the following: a. One hundred percent of covered expenses following the payment of the annual deductible set forth in subparagraph h; b. The basic core benefit as defined in Ins 1905.08 (b); plus c. One hundred percent of the Medicare Part A deductible as defined in Ins 1905.08 (c)(1); d. Skilled nursing facility care as defined in Ins 1905.08 (c)(3); e. One hundred percent of the Medicare Part B deductible as defined in Ins 1905.08 (c)(4); f. One hundred percent of the Medicare Part B excess charges as defined in Ins 2905.08 (c)(5); and g. Medically necessary emergency care in a foreign country as defined in Ins 1905.08 (c)(6).h. The annual deductible in plan “F” with high deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by regular plan “F”, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be $1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the consumer price index for all urban consumers for the 12 month period ending with August of the preceding year, and rounded to the nearest multiple of 10 dollars. |  |  |
| Plan G |  | (e) (7) Standardized Medicare supplement benefit plan “G” shall include only the following: a. The basic core benefit as defined in Ins 1905.08 (b); plus b. One hundred percent of the Medicare Part A deductible as defined in Ins 1905.08 (c)(1); c. Skilled nursing facility care as defined in Ins 1905.08 (c)(3); d. One hundred percent of the Medicare Part B excess charges as defined in Ins 1905.08 (c)(5); and e. Medically necessary emergency care in a foreign country as defined in Ins 1905.08 (c)(6). |  |  |
| Plan K |  | (e) (8) Standardized Medicare supplement plan “K” is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following: a. Part A Hospital Coinsurance, 61st through 90th days: Coverage of 100% of the Part A hospital coinsurance amount for each day from the 61st through the 90th day in any Medicare benefit period; b. Part A Hospital Coinsurance, 91st through 150th days: 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; c. Part A Hospitalization After 150 Days: 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;d. 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 j. e. 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 j. f. 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 j. g. Blood: Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, and defined under federal regulations, unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph j. h. Part B Cost Sharing: Except for coverage provided in subparagraph i, 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 j.i. Part B Preventive Services: Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and j. Cost Sharing After Out-of-Pocket Limits: 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 $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services. |  |  |
| Plan L |  | (e) (9) Standardized Medicare supplement plan “L” is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following: a. The benefits described in Ins 1905.10 (e)(8)a., b., c., and i.; b. The benefit described in Ins 1905.10 (e)(8)d., e., f., g., and h., but substituting 75% for 50%; and c. The benefit described in Ins 1905.10 (e)(8)i., but substituting $2,000 for $4,000. |  |  |
| Plan M |  | (e) (10) Standardized Medicare supplement plan “M” shall include only the following: a. The basic core benefit as defined in Ins 1905.08 (b); plus b. Fifty percent of the Medicare Part A deductible as defined in Ins 1905.08 (c)(2); c. Skilled nursing facility care as defined in Ins 1905.08 (c)(3); and d. Medically necessary emergency care in a foreign country as defined in Ins 1905.08 (c)(6). |  |  |
| Plan N |  | (e) (11) Standardized Medicare supplement plan “N” shall include only the following: a. The basic core benefit as defined in Ins 1905.08 (b); plus b. One hundred percent of the Medicare Part A deductible as defined in Ins 1905.08 (c)(1); c. Skilled nursing facility care as defined in Ins 1905.08 (c)(3); and d. Medically necessary emergency care in a foreign country as defined in Ins 1905.08 (c)(6), with copayments in the following amounts: 1. 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 2. 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. |  |  |
| Standard Medicare Supplement Benefit Plans for 2020 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery to Individuals Newly Eligible for Medicare On or After January 1, 2020 | Ins 1905.11 | (a)(3) Standardized Medicare supplement benefit plans C, F, and F with High Deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020; (4) Standardized Medicare supplement benefit Plan F With High Deductible is redesignated as Plan G With High Deductible and shall provide the benefits contained in Ins 1905.10(e)(6) but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible, provided further that the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible; and (5) The reference to Plans C or F contained in Ins 1905.10(a)(2) is deemed a reference to Plans D or G for purposes of this section. (b) Applicability to Certain Individuals. Ins 1905.11 applies to only individuals that are newly eligible for Medicare on or after January 1, 2020: (1) By reason of attaining age 65 on or after January 1, 2020; or (2) By reason of entitlement to benefits under part A pursuant to Section 226(b) or 226A of the Social Security Act, available as referenced in Appendix A, or who is deemed to be eligible for benefits under Section 226(a) of the Social Security Act on or after January 1, 2020. (c) Guaranteed Issue for Eligible Persons. For purposes of Ins 1905.14(e), in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F With High Deductible) shall be deemed to be a reference to Medicare supplement policy D or G (including G With High Deductible), respectively, that meet the requirements of Ins 1905.11(a). (e) Offer of Redesignated Plans to Individuals Other Than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in subparagraph Ins 1905.11(a)(4), above, may be offered to any individual who was eligible for Medicare prior to January 1, 2020, in addition to the standardized plans described in Ins 1905.10(e). |  |  |
| Plan D | Ins 1905.11 (a) | Benefit Requirements. The standards and requirements of Section Ins 1905.10 shall apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions: (1) Standardized Medicare supplement benefit Plan C is redesignated as Plan D and shall provide the benefits contained in Ins 1905.10(e)(3) but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible; |  |  |
| Plan G | Ins 1905.11 (a) | (2) Standardized Medicare supplement benefit Plan F is redesignated as Plan G and shall provide the benefits contained in Ins 1905.10(e)(5) but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible; |  |  |
| Outline of Coverage | Ins 1905.19 (d) | (1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of the outline from the applicant; and (2) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."(3) The outline of coverage provided to applicants pursuant to this section shall consist of 4 parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12 point type. All plans A-L shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. 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 illustrated. (4) The following items shall be included in the outline of coverage in the order prescribed below. (See NHCAR Part Ins 1905.19 (d)) |  |  |
| Claims Payment StandardsID Cards | Ins 1905.15 | (a) An issuer shall comply with Section 1882(c)(3) of the Social Security Act, as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987, OBRA, 1987, Public Law No. 100-203 by: (1) Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice; (2) Notifying the participating physician or supplier and the beneficiary of the payment determination; (3) Paying the participating physician or supplier directly; (4) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent; (5) Paying user fees for claim notices that are transmitted electronically or otherwise; and (6) Providing to the secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers. |  |  |

V. MEDICARE SUPPLEMENT RATE REQUIREMENTS

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| Rates |  |  |  |  |
| Loss Ratio Standards | Ins 1905.16  | Loss Ratio Standards and Refund or Credit of Premium. |  |  |
| Rates | Ins 1905.17 | Filing and Approval of Policies and Certificates and Premium Rates. |  |  |
| Issue age | Ins 1905.17 (j) | An issuer shall present for filing or approval a rate structure for its Medicare supplement policies or certificates issued after the effective date of the amendment of this rule based upon issue age only. |  |  |

VI. INFORMATIONAL MEDICARE SUPPLEMENTAL ISSUES

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| Other - Permitted Compensation Arrangements | Ins 1905.18 | (a) An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than 200% of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period. (b) The commission or other compensation provided in subsequent renewal years shall be the same as that provided in the second year or period and shall be provided for no fewer than 5 renewal years. |  |  |
| Advertising | Ins 2603 | See Bulletin Ins 22-003-AB *Medicare Supplement Advertising and Lead Generating Devices Require Approval* |  |  |
| Prohibited Practices | RSA 417:4Ins 1905.22 (b) | XXIII. Medicare Products and Medicare Supplemental Health Insurance. (a)(1) Selling, soliciting or negotiating the purchase of Medicare products (Part C and Part D) or Medicare supplemental (Medigap) health insurance in this state through the use of cold lead advertising. (2) Using an appointment that was made to discuss Medicare products or to solicit the sale of Medicare products in order to solicit sales of life insurance or annuity products. (3) Soliciting the sale of Medicare products door-to-door prior to receiving an invitation from a consumer. (b) In this paragraph: (1) "Cold lead advertising'' means making use directly or indirectly of a method of marketing that fails to disclose in a conspicuous manner that a purpose of the marketing is insurance sales solicitation and that a contact will be made by an insurance producer or insurance company.(b) In addition to the practices prohibited in RSA 417 the following acts and practices are prohibited: (1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, 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. (2) High pressure tactics. Employing any method of marketing having the effect of or tending 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. (3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company. |  |  |

VII. COMMENTS: