The Florida Office of Insurance Regulation (Office) developed the following worksheet to assist companies in drafting and submitting a Medicare Supplement Contract for review by the Office. The Office encourages, but does not require, the company to download, complete, scan, and upload this form as part of the form filing as it will expedite the review process. The Office offers this worksheet as guidance only and it should not be considered a directive by the Office. The worksheet does not contain all of the requirements for Medicare Supplement filings, but instead incorporates guidance for point of law frequently overlooked in filings.

MEDICARE SUPPLEMENT CONTRACT WORKSHEET
Individual and Group
Standard and Select Plans

STATUTE/RULE	FILING COMPLIANCE	YES	NO	N/A	PAGE #
	MEDICARE SUPPLEMENT FILING REQUIREMENTS				
69O-149.021	Required information to be submitted within the filing.				
69O-149.023(4)	Include a description of the distribution system and intended target population.				
69O-149.021(6)(c)	The Office will ask for form number(s), date(s) of approval, Florida file number(s), (e.g. FLH 19-234560), and type of coverage of all policies or other related forms to be used or issued in connection with the form(s) submitted.				
627.4145(3)	Certificate of Readability signed by an officer of the company.				
627.602(1)(d)	Requires text to be at least 10-point type.				
627.602(1)(f)	All contracts and related forms shall contain a form number in the lower left-hand corner.				
69O-156.012	Filing & Approval of Policies, Certificates & Rates.				
627.674	Minimum Standards; filing requirements				
	POLICY / CERTIFICATE COVER PAGE				
69O-154.001	Important Notice must appear in a prominent manner. The insured must notify the company within 10 days of any incomplete or incorrect information on the application.				
69O-156.014(1)(a)	Required Disclosure Provision: the renewal or continuation provision shall be appropriately captioned and on the first page of the policy/certificate. Shall include any reservation by the insurer to change premiums.				
69O-156.014(1)(e)	Required Disclosure Provision: 30-day free look, the policyholder shall have the right to return the policy and the premium shall be refunded if the insured person is not satisfied with the policy for any reason.				
69O-156.016(1)(c)	Required Disclosure Statement: Display prominently the following - "Notice to buyer: This policy may not cover all of your medical expenses."				
627.602(2)	If the contract has a deductible provision, it should be on the first page of the policy/certificate in at least 18-point type.				

STATUTE/RULE	FILING COMPLIANCE	YES	NO	N/A	PAGE #
	POLICY / CERTIFICATE CONTENTS				
627.413(1)(b)	Specify the type / subject of insurance; policy must have a title.				
627.413(1)(a)	List the names of the parties to the contract.				
627.416	Every form shall contain the signature of a company official.				
627.602(1)(c)	Policy must identify the person who is insured.				
627.602(1(b)	Detail the time the policy takes effect and terminates.				
627.413(1)(d)	The time the insurance takes effect and the period it continues.				
627.413(1)(g) 627.402(3)	Include the form numbers and edition dates of all endorsements attached to the policy, only at time of original issue.				
627.606	The entire contract: list all forms (application and attached papers) that apply.				
627.616	Legal action: no legal action may be brought within 60 days after written proof of loss given, or after 5-year statute of limitations – Section 95.11(2)(b), F.S.				
69O-156.014(1)(b)	Riders or endorsements which reduce or eliminate benefits must be signed by insured.				
627.617	Change of beneficiary, unless irrevocable.				
627.607	The Time Limit on Certain Defenses: 2-year maximum. (May include Incontestable provision instead.)				
627.620	Misstatement of age or sex.				
627.627	Conformity with State Statutes: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.				
	RATES AND PREMIUMS				
627.413(1)(e)	The premium (may be located on the application or Schedule of Benefits, if application/schedule is made part of the policy.)				
69O-156.014(1)(f)	Insurer must provide a 45-day advance notice of rate change.				
	BENEFITS				
627.602(1)(a)	The monetary and other considerations are to be expressed in the form.				
627.413(1)(c)	The risk insured against and benefits provided by the company.				

STATUTE/RULE	FILING COMPLIANCE	YES	NO	N/A	PAGE #
	PAYMENT OF BENEFITS / CLAIMS				
627.413(1)(f)	The conditions pertaining to the insurance – qualifications necessary to receive benefits.				
627.610	Notice of claim provision: Written notice of claim must be given within 20 days or as soon as reasonably possible.				
627.611	Claim Forms: Company to provide within 15 days, or claimant can meet the requirement by giving insurer a written statement.				
627.612	Proof of loss: Must be given within a minimum of 90 days or as soon as reasonably possible - no later than 1 year.				
627.613	Time of payment of claims: Company must pay upon receipt of proper written proof of loss.				
627.614	Payment of claims: Benefits will be paid to insured. Any other benefits unpaid at death may be paid to the estate.				
627.6141	Denial of claim as not medically necessary– company response must not exceed fifteen (15) business days.				
627.615	Physical examinations, autopsy: At company's expense.				
69O-156.005(3)	Policy Provision: No duplication of Medicare benefits.				
69O-156.014(1)(c)	Shall not provide for the payment of benefits based in standards described as "usual/reasonable" or "customary" language.				
627.657(3)	Group health policies must include the following provisions: Sections 627.610, 627.612, 627.613 and 627.616, F.S.				
	LIMITATIONS AND EXCLUSIONS				
627.602(1)(e)	Requires listing of exceptions and reductions. Must be clearly stated and not ambiguous.				
69O-156.005(1)	Limitations or exclusions may not be more restrictive than those exclusions used by Medicare.				
	PRE-EXISTING CONDITIONS				
69O-156.005(2)	Prohibition on excluding or limiting or reducing coverage for specifically named diseases or physical conditions.				
69O-156.014(1)(d)	Pre-existing condition limitation must be in a separate paragraph.				
69O-156.019	Prohibition against Preexisting Conditions, Waiting Periods, Elimination Periods, & Probationary periods in Replacement Policies or Certificates.				

STATUTE/RULE	FILING COMPLIANCE	YES	NO	N/A	PAGE #
	CANCELLATION / REINSTATEMENT / CONTINUATION				
627.6741(2)	An insurer shall only cancel for nonpayment of premium or material misrepresentation.				
627.6741(3)	For group Medicare supplement policies: Conversion right.				
627.6741(4)	Cancellation – company must promptly return the unearned portion of any premium paid.				
627.608	Grace Period.				
627.609	Reinstatement.				
	DEFINITIONS				
627.672 69O-156.003(13)	Definitions: Medicare Supplement Policy.				
69O-156.003(17)	Required Policy Definitions and Terms: Pre-existing Condition				
69O-156.004(1)	Required Policy Definitions and Terms: (1) Accident, (2) Benefit Period, (3) Skilled Nursing Facility, (4) Health Care Expenses, (5) Hospital, (6) Medicare, (7) Medicare Eligible Expenses, (8) Physician, (9) Sickness If a term is used in the contract, it must be defined as no more restrictive than these definitions.				
	BENEFIT STANDARDS: PRE-MACRA				
69O-156.0085	Standard Medicare Supplement benefit plans for 2010 standardized Medicare Supplement Benefit Policies or Certificates issued for delivery with an effective date after 6/1/2010.				
69O-156.0075(2)	Standards for Core benefits - Plans C, F & High Deductible F.				
69O-156.0085(5)(c)(e)(f)	Standards for additional benefits - Plans C, F & High Deductible F.				
69O-156.0075(1)(a)-(g)	General Benefit Standards for 2010 Medicare Supplement Policies or Certificates issued for delivery after 6/1/2010.				

STATUTE/RULE	FILING COMPLIANCE	YES	NO	N/A	PAGE #
	BENEFIT STANDARDS - MACRA				
69O-156.0086 MACRA	**Standard Medicare Supplement benefit plans for 2020 standardized Medicare supplement benefit policies or certificates issued for delivery with an effective date on or after 1/1/2020. (Plans C, F & High Deductible F prohibited for Newly Eligible Beneficiaries.)**				
69O-156.0086(6)(a) MACRA	**Standards for Core benefits – Plans A, B, D, G, K, L, M, & N.**				
69O-156.0086(6)(c)-(i) MACRA	**Standards for additional benefits - Plans B, D, G, K, L, M, & N.**				
69O-156.0086(6)(e) MACRA	**Standards for Core and additional benefits – Plan G High Deductible.**				
69O-156.0075(1)(a)-(g)	**General Benefit Standards for all Medicare Supplement Policies or Certificates issued for delivery after 6/1/2010.**				
	MEDICARE SELECT				
69O-156.030	**Standards for Medicare Select Policies & Certificates.**				
	OPEN ENROLLMENT / GUARANTEE ISSUE				
69O-156.009	**Open Enrollment**				
69O-156.0095	**Guarantee Issue for Eligible Persons.**				
627.6741(1)	**Those insureds who are disabled or have End Stage Renal Disease must be included in the contract.**				

Additional Notes:

Please upload all documents with document titles that accurately reflect their contents including specific form numbers in the "Forms to Be Reviewed" section of the Universal Standard Data Letter (UDL).