

Wyoming Insurance Department

Review Requirement Checklist

Individual or Group Medicare Supplement

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Wyoming Insurance Department	Statutes	http://legisweb.state.wy.us
Wyoming Insurance Department	Rules and Regulations	http://soswy.state.wy.us
Wyoming Insurance Department	Memoranda/Dept. Position	
REVIEW REQUIREMENTS	REFERENCE	COMMENTS
General Requirements	W.S. §26-15-110	Filing Requirements
Transmittal Letter	Wyoming Uniform Filing Procedure	All filings shall:
		Contain the company's name, address, NAIC number and company phone number.
		Be sent in duplicate.
		Have a self-addressed, postage paid envelope.
		Have a "SUBJECT" line briefly describing the filing type.
		Contain an itemized listing of each policy form and endorsement, including form number.
		Contain the name of the individual responsible for the preparation of the filing.
		Contain a Certification of Compliance signed by an officer of the company, attorney or actuary.
Actuarial Memorandum	W.S. §26-15-111	Shall certify rates are reasonable in relation to the benefits provided.

Forms		No filing fee for rate or form filings.
Policy Contents and Identification	W.S. §26-15-113	The policy shall specify: -the names of the parties to the contract; -the subject of the insurance; -the risks insured against; -the time when the insurance takes effect and the period during which the insurance continues; -the premium; -the conditions pertaining to the insurance; and -benefits payable.
Renewal or Extension	W.S. §26-15-121	The policy shall be renewable at the option of the insured except for: -nonpayment of premium; or -fraud or misrepresentation by the insured.
Assignability	W.S. §26-15-122	The policy is assignable or not assignable as provided by its terms.
Proceeds Exempt From Creditors	W.S. §26-15-130	Except as otherwise provided by the policy or contract, the proceeds are exempt from claims of creditors.
Prohibited Provisions	W.S. §26-38-203; Reg., Ch.35	Duplication of Medicare benefits are prohibited. Certain limitations and exclusions allowed cannot be more restrictive than Medicare. Waivers for specific pre-existing conditions prohibited.
Minimum Benefits	Reg., Ch.35, §§ 7 & 8	Part A expenses for hospital days sixty one to ninety (61 - 90). All or none of Part A deductible. Part A expenses during the use of lifetime reserve days. Ninety (90) percent of Part A hospital expenses after exhaustion of all days including lifetime reserve days. Part A and B blood deductible. Part B coinsurance or applicable hospital outpatient copayment. Part B blood deductible Medicare eligible expenses defined.

General Standards	Reg., Ch. 35, § 8	<p>Ninety (90) days on pre-existing conditions definition and the policy or certificate cannot define a pre-existing condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within ninety (90) days before the effective date of coverage.</p> <p>Benefits do not distinguish between sickness and accidents.</p> <p>Benefits designed to cover coinsurance and Medicare deductible expenses will be changed automatically to coincide with changes in Medicare. Premiums may be modified to correspond with such changes.</p> <p>Notice required that policy may not cover all expenses.</p> <p>Replacement policies must waive specified time periods to the extent that such time was spent under the original policy.</p>
Termination, Cancellation, Renewal, Conversion & Replacement.	Reg., Ch. 35, § 8 & 18	<p>Noncancellable and/or guaranteed renewable provision requirements.</p> <p>Cancellation and nonrenewal prohibited; exceptions.</p> <p>Renewal provision required; stipulations for replacement.</p> <p>Conversion requirements.</p> <p>Group replacement requirements.</p> <p>Replacement policies must waive specified time periods to the extent that such time was spent under the original policy.</p>
Claims Settlement	Reg., Ch. 35, § 8	Termination of policy shall not prejudice continuing loss.
Standardized Plans	Reg., Ch. 35, § 9	Requirement to make available standardized Plan A and any of standardized Plans B through J plus high deductible Plans F and J.
Medicare Select	Reg., Ch 35, § 10	Requirements to offer Medicare Select policies and certificates.
Open Enrollment	Reg., Ch 35, § 11	Nondiscrimination required. Portability credit for continuous coverage with a break in coverage not to exceed ninety (90) days.
Guaranteed Issue	Reg., Ch 35, § 12	Requires guarantee issue to certain classes of eligible persons and describes the products to which eligible person are entitled. Notification of rights to guaranteed issue to be communicated contemporaneously with notification of termination or disenrollment.

Loss Ratio Standards	Reg., Ch. 35, §§ 14 & 15	Seventy-five (75) percent of aggregate earned premium on group policies and Sixty-five (65) percent on individual. Annual filing of rates and supporting documentation required; criteria for compliance. Re-filing of forms due to Medicare benefit changes required.
Compensation Arrangements	Reg., Ch. 35, § 16	Limits on amount of first year commission. Renewal Commission required and standards for paying same. Requirements for commission on a replacement policy. Compensation defined.
Policy Changes	Reg., Ch. 35, § 17	Riders or endorsements reducing coverage after effective date require signed acceptance; exceptions; riders increasing coverage and premium. Notice of changes in coverage and premium, in outline form, at least thirty (30) days in advance of Medicare changes; include description of Medicare revisions. Notice of changes cannot be accompanied by a solicitation.
Required Disclosure Provisions	Reg., Ch. 35, § 17	No payment based upon usual, customary and reasonable. Pre-existing condition limitations must appear as a separate paragraph and be so labeled. Thirty (30) day right to return policy. Medicare Supplement Buyer's Guide required; time of delivery mandated.
Outline of Coverage	Reg., Ch.35, §§ 17 & 19	Outline delivered at time of application; exceptions for direct response. Outline contents (W.S. 26-38-206(b)) Replacement outlines delivered with policy; prominent notice mandated. Outline of coverage format prescribed. Policies that are not Medicare Supplements, issued to people eligible for Medicare by reason of age, shall have a notice stating it is not a Medicare Supplement policy, attached to front; contents prescribed. Notice required that policy may not cover all expenses.
Application Contents	Reg., Ch. 35., § 18	Contents of application prescribed. Notice regarding replacement required in advance of delivery. Contents of notice prescribed.
Advertising	W.S. §26-38-208	Advertisements to be submitted for approval.
Marketing	Reg., Ch. 35, § 19	Established marketing procedures required. Established auditable procedures to verify compliance required.
Prohibited Practices	Reg., Ch. 35, § 19	Twisting/misrepresentation. High pressure tactics. Cold lead advertising.

Appropriateness of Recommended Purchase & Excessive Insurance	Reg., Ch. 35, § 20	Agent to make reasonable effort to determine appropriateness of recommended purchase. More than one (1) Medicare Supplement policy is prohibited.
Reporting of Multiple Policies	Reg., Ch. 35, § 21	Certain information to be reported on individuals to whom more than one Medicare Supplement Policy has been issued. Ref. APPENDIX B.
Prompt Payment	W.S. §26-15-124	Claims shall be rejected or accepted and paid within 45 days of receipt of proofs of loss and supporting documentation.
Incontestability	W.S. §26-18-106	Policy shall be incontestable after a three (3) year period.
Grace Period	W.S. §26-18-107	A grace period of thirty-one (31) days shall be granted for the payment of premiums after the first, during which grace period the policy shall continue in force..
Physical Examination & Autopsy	W.S. §26-18-114	Insurer, at its own expense, has this right.
Legal Action	W.S. §26-18-115	No action at law or in equity to be brought prior to the expiration of sixty (60) days after written proof of loss nor the expiration of three (3) years.