



ADMINISTRATIVE RULES OF MONTANA



6.6.5079G CERTIFICATION OF CREDITABLE COVERAGE - GROUPS AND INDIVIDUALS

- (1) A group health plan, and each health insurance issuer offering group health insurance coverage under a group health plan, is required to issue certificates of creditable coverage in accordance with 33-22-142, MCA, and this rule. A health insurance issuer offering health insurance coverage in the individual market is required to issue certificates of creditable coverage in accordance with this rule, notwithstanding references in this rule to "group health plan" and "plan".
- (2) Certificates required under 33-22-142(1) (a) and (b) , MCA, must be mailed or hand-delivered to the individual within a reasonable time. Certificates provided under 33-22-142(1) (c) , MCA, must be mailed or hand-delivered within 7 days of the receipt of the request by the plan or the health insurance issuer or a designee of either.
- (3) No automatic written certificate of creditable coverage is required to be provided to an individual if:
 - (a) An individual is entitled to receive a certificate;
 - (b) The individual requests that the certificate be sent to another plan or issuer instead of to the individual; and
 - (c) The plan or issuer that would otherwise receive the certificate agrees to accept the information through means other than a written certificate (for example, by telephone or electronic mail) .
- (4) The certification must contain:
 - (a) The date the certificate is issued;
 - (b) The name of the group health plan that provided the coverage described in the certificate;
 - (c) The name of the participant or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan and the name of the participant if the certificate is for, or includes, a dependent;
 - (d) The name, address, and telephone number of the plan administrator or issuer required to provide the certificate, and the telephone number to call for further information regarding the certificate; and
 - (e) Either:
 - (i) A statement that an individual has at least 18 months (for this purpose, 546 days is deemed to be 18 months) of creditable coverage, disregarding days of creditable coverage before a significant break in coverage; or

- (ii) The date any waiting period (and affiliation period, if applicable) began and the date creditable coverage began;
 - (iii) The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate; and
 - (iv) Information required under 33-22-142, MCA.
- (5) If an individual requests a certificate under 33-22-142(1) (c) , MCA, a certificate must be provided for each period of continuous coverage ending within the 24-month period ending on the date of the request, or continuing on the date of the request. A separate certificate may be provided for each such period of continuous coverage.
- (6) A certificate may provide information with respect to both a participant and the participant's dependents if the information is identical for each individual or, if the information is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.
- (7) The certificate must be provided to each covered individual or to an entity requesting the certificate on behalf of an individual. The certificate may be provided by first-class mail. If the certificate or certificates are provided to the

participant and the participant's spouse at the participant's

last known address, then the requirement is satisfied with

respect to all individuals residing at that address. If a

dependent's last known address is different than the

participant's last known address, a separate certificate must be provided to the dependent at the dependent's last known address. If separate certificates are being provided by mail to individuals who reside at the same address, separate mailings of each certificate are not required.
- (8) A plan or issuer must establish a procedure for individuals to request and receive certificates under 33-22-

142(1) (c) , MCA.
- (9) If an automatic certificate is required to be provided, and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is permitted to provide the certificate to the designated party. If a certificate is required to be provided upon request and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is required to provide the certificate to the designated party.
- (10) A plan or issuer is required to use reasonable efforts to determine any information needed for a certificate relating to the dependent coverage. In any case in which an automatic certificate is required to be furnished, no individual certificate is required to be furnished until the plan or issuer knows, or making reasonable efforts should know, of the dependent's cessation of coverage under the plan.

- (11) Issuers of group and individual health insurance are required to provide certificates of any creditable coverage they provide in the group or individual health insurance market, even if the coverage is provided in connection with an entity or program that is not itself required to provide a certificate because it is not subject to the group market provisions of the Health Insurance Portability and Accessibility Act, PL 104-191 and Title 33, chapter 22, MCA. However, a certificate is not required to be provided with respect to short-term limited duration insurance that is not provided in connection with a group health plan.
- (12) If the accuracy of a certificate is contested or a certificate is unavailable when needed by an individual, the individual has the right to demonstrate creditable coverage (and waiting or affiliation periods) through the presentation of documents or other means. For example, the individual may make such a demonstration when:
- (a) An entity has failed to provide a certificate within a reasonable or required time period;
 - (b) The individual has creditable coverage but an entity may not be required to provide a certificate of the coverage;
 - (c) The coverage is for a period before July 1, 1996;
 - (d) The individual has an urgent medical condition that necessitates a determination before the individual can deliver a certificate to the plan; or
 - (e) The individual lost a certificate that the individual had previously received and is unable to obtain another certificate.
- (13) In case of an individual attempting to demonstrate creditable coverage under (12) , a plan or issuer is required to take into account all information that it obtains or that is presented on behalf of an individual to make a determination, based on the relevant facts and circumstances, whether an individual has creditable coverage and is entitled to offset all or a portion of any preexisting condition exclusion period. A plan or issuer shall treat the individual as having furnished a certificate if the individual attests to the period of creditable coverage, the individual also presents relevant corroborating evidence of some creditable coverage during the period, and the individual cooperates with the plan's or issuer's efforts to verify the individual's coverage. For this purpose, cooperation includes providing, upon the plan's or issuer's request, a written authorization for the plan or issuer to request a certificate on behalf of the individual, and cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage. while a plan or issuer may refuse to credit coverage where the individual fails to cooperate with the plan's or issuer's efforts to verify coverage, the plan or issuer may not consider an individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.
- (14) In the absence of a certificate, documents which may establish creditable coverage under (12) , including categories of creditable coverage and waiting or affiliation periods, include explanations of benefit claims (EOB) or other correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage. The information may also be established through means other than documentation, such as by a telephone call from the plan or provider to a third party verifying creditable coverage.
- (15) If, in the course of providing evidence, including a certificate, of creditable coverage, an individual is required to demonstrate dependent status, the group health plan or issuer must treat the

individual as having furnished a certificate showing the dependent status if the individual attests to such dependency and the period of such status and the individual cooperates with the plan's or issuer's efforts to verify the dependent status.

- (16) In the event that a group health plan or health insurance issuer offering group health insurance coverage receives a certification of creditable coverage, information regarding categories of coverage, or through the alternative method set forth in (12) , the entity must, within a reasonable time period following receipt of the information, make a determination regarding the individual's period of creditable coverage and notify the individual in writing of the determination. Whether a determination and notification regarding an individual's creditable coverage is made within a reasonable time period is determined based on the relevant facts and circumstances. Relevant facts and circumstances include whether a plan's application of a preexisting condition exclusion would prevent an individual from having access to urgent medical services.
- (17) A plan or issuer seeking to impose a preexisting condition exclusion is required to disclose to the individual, in writing, its determination of any preexisting condition exclusion period that applies to the individual, and the basis for such determination, including the source and substance of any information on which the plan or issuer relied. In addition, the plan or issuer is required to provide the individual with a written explanation of any appeal procedures established by the plan or issuer, and with a reasonable opportunity to submit additional evidence of creditable coverage. However, nothing in this rule prevents a plan or issuer from modifying an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage, provided that:
 - (a) A notice of the reconsideration is provided to the individual; and
 - (b) Until the final determination is made, the plan or issuer, for purposes of approving access to medical services (such as a pre-surgery authorization) , acts in a manner consistent with the initial determination.
- (18) If an individual's coverage under an issuer's policy ceases before the individual's coverage under the plan ceases, the issuer is required to provide sufficient information to the plan, or to another party designated by the plan, to enable a certificate to be provided by the plan (or other party) , after cessation of the individual's coverage under the plan, that reflects the period of coverage under the policy. The provision of that information to the plan will satisfy the issuer's obligation to provide certification under 33-22-142(1) (a) and (b) , MCA. In addition, an issuer providing that information is required to cooperate with the plan in responding to any request relating to the alternative method of counting creditable coverage, and to any request made by an individual pursuant to 33-22-142(1) (c) , MCA.
- (19) This section of this rule applies to establishing creditable coverage for dependents only through June 30, 1998. A group health plan or health insurance issuer that cannot provide the names of dependents, or related coverage information, for purposes of providing a certificate of coverage for a dependent may satisfy the requirements to do so by providing the name of the participant covered by the group health plan or health insurance issuer and specifying that the type of coverage described in the certificate is for dependent coverage, such as family coverage or employee-plus-spouse coverage. For purposes of certificates provided on the request of, or on behalf of, an individual under 33-22-142(1) (c) , MCA, a plan or issuer must make reasonable efforts to obtain and provide the names of any dependent covered by the certificate where such information is requested to be provided. If it does not include the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures

described in (12) for submitting documentation to establish that the creditable coverage in the certificate applies to the dependent.

Authorizing statute(s): Sec. 33-22-142(3) (v) and 33-22-143, MCA

Implementing statute(s): Sec. 33-22-142, MCA

History: NEW, 1998 MAR p. 1698, Eff. 6/26/98.