



ADMINISTRATIVE RULES OF MONTANA

6.6.507E STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 2010 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1, 2010

- (1) The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates with an effective date for coverage before June 1, 2010, remain subject to the requirements of ARM 6.6.507A.
- (2) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic "core" benefits, as established in ARM 6.6.507D(4).
- (3) If an issuer makes available any of the additional benefits described in ARM 6.6.507D(4)(b) or offers standardized benefits Plans K or L (as described in ARM 6.6.507E(8)(a) and (b) of this subchapter), 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 (2), a policy form or certificate form containing either Standardized Benefit Plan C (as described in ARM 6.6.507E(7)(c) of this subchapter) or Standardized Benefit Plan F (as described in ARM 6.6.507E(7)(e) of this subchapter).
- (4) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this rule shall be offered for sale in this state, except as may be permitted in ARM 6.6.507E(11) and ARM 6.6.601-614 of these rules.
- (5) Benefit plans must be uniform in structure, language, designation and format to the standard benefit plans listed in this rule and conform to the definitions in 33-22-903, MCA, and ARM 6.6.505. Each benefit shall be structured in accordance with the format provided in ARM 6.6.507D(4)(a) and (b); or in the case of Plans K or L, in ARM 6.6.507E(8)(a) and (b), and list the benefits in the order shown in this rule. For purposes of this rule, "structure, language, and format" means style, arrangement and overall content of a benefit.
- (6) An issuer may use, in addition to the benefit plan designations required in (5), other designations to the extent permitted by law.
- (7) The following descriptions detail the contents of the 2010 standardized benefit plans:
 - (a) Standardized Medicare Supplement Benefit Plan A must be limited to the basic ("core") benefits common to all benefit plans, as established in ARM 6.6.507D(4)(a);

- (b) Standardized Medicare Supplement Benefit Plan B must include only the core benefit as established in ARM 6.6.507D(4)(a), plus 100% of the Medicare Part A deductible as established in ARM 6.6.507D(4)(b)(i).
 - (c) Standardized Medicare Supplement Benefit Plan C must include only the core benefit, as established in ARM 6.6.507D(4)(a), plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as established in ARM 6.6.507D(4)(b)(i), (iii), (iv), and (vi), respectively.
 - (d) Standardized Medicare Supplement Benefit Plan D must include only the core benefit, as established in ARM 6.6.507D(4)(a), plus 100% of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country, as established in ARM 6.6.507D(4)(b)(i), (iii), and (vi), respectively.
 - (e) Standardized Medicare Supplement Benefit regular Plan F must include only the core benefit as established in ARM 6.6.507D(4)(a), plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country, established in ARM 6.6.507D(4)(b)(i), (iii), (iv), (v), and (vi), respectively.
 - (f) Standardized Medicare Supplement Benefit High Deductible Plan F shall include only 100% of covered expenses following the payment of the annual High Deductible Plan F deductible.
 - (i) "Covered expenses" for this subsection are the core benefit as defined in ARM 6.6.507D(4)(a), plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in ARM 6.6.507D(4)(b)(i), (iii), (iv), (v), and (vi), respectively.
 - (ii) The "annual high deductible Plan F deductible" must consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement regular Plan F policy, and must be in addition to any other specific benefit deductibles. The basis for the deductible will be \$1500 and will be adjusted annually from 1999 by the Secretary 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.
 - (g) Standardized Medicare Supplement Benefit Plan G must include only the core benefit as established in ARM 6.6.507D(4)(a), plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as established in ARM 6.6.507D(4)(b)(i), (iii), (v), and (vi), respectively. Effective January 1, 2020, the standardized benefit plans described in ARM 6.6.507F(2)(d) (Redesignated Plan G High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.
- (8) The following descriptions detail the contents of two Medicare supplement plans authorized by the MMA:
- (a) Standardized Medicare Supplement Benefit Plan K must consist of only the following benefits:

- (i) coverage of 100% of the Part A hospital coinsurance amount for each day used from the 61st day 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 the balance;
 - (iv) 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 (x);
 - (v) coverage for 50% of the coinsurance amount for each day used for 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 (x);
 - (vi) 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 (x);
 - (vii) coverage for 50%, under Medicare Part A or B of 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 until the out-of-pocket limitation is met as described in (x);
 - (viii) except for coverage provided in (ix) of this subsection, coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder or certificateholder pays the Part B deductible until the out-of-pocket limitation is met as described in (x);
 - (ix) coverage of 100% of the cost sharing for Medicare Part B preventative 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.
- (b) Standardized Medicare Supplement Benefit Plan L must consist of only the following benefits:
- (i) the benefits described in (8)(a)(i), (ii), (iii), and (ix);
 - (ii) the benefit described in (8)(a)(iv), (v), (vi), (vii) and (viii), but substituting 75% for 50%; and
 - (iii) the benefit described in (8)(a)(x), but substituting \$2000 for \$4000.
- (9) Standardized Medicare Supplement Plan M shall include only the basic (core) benefit as defined in ARM 6.6.507D(4)(a), plus 50% of the Medicare Part A deductible, skilled nursing facility care, and

medically necessary emergency care in a foreign country, as defined in ARM 6.6.507D(4)(b)(ii), (iii), and (vi), respectively.

- (10) Standardized Medicare Supplement Plan N shall include only the basic (core) benefit as defined in ARM 6.6.507D(4)(a), plus 100% of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country, as defined in ARM 6.6.507D(4)(b)(i), (iii), and (vi), respectively, with copayments in the following amounts:
- (a) the lesser of \$20 or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialist); and
 - (b) the lesser of \$50 or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, the 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.
- (11) An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits must include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, are cost-effective, and are offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. New or innovative benefits must not include an outpatient prescription drug benefit. New or innovative benefits may not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

Authorizing statute(s): 33-1-313, 33-22-904, 33-22-905, MCA

Implementing statute(s): 33-15-303, 33-22-901, 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-909, 33-22-910, 33-22-911, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA

History: NEW, 2009 MAR p. 1107, Eff. 7/17/09; AMD, 2013 MAR p. 1819, Eff. 10/18/13; AMD, 2015 MAR p. 1049, Eff. 7/31/15; AMD, 2018 MAR p. 572, Eff. 3/17/18.