



ADMINISTRATIVE RULES OF MONTANA

6.6.507D BENEFIT STANDARDS FOR 2010 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY 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 with an effective date for coverage on or after June 1, 2010, unless it complies with these benefit standards. No issuer may offer any 1990 Standardized Medicare Supplement Benefit Plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage before June 1, 2010, remain subject to the requirements of ARM 6.6.507 and other applicable rules and statutes contained in this subchapter and Title 33, chapter 22, part 9, MCA.
 - (a) The following standards are in addition to all other requirements of this subchapter and Title 33, chapter 22, part 9, MCA, Medicare Supplement Insurance Minimum Standards:
 - (i) a Medicare supplement policy or certificate must not exclude or limit benefits for a loss incurred more than six months from the effective date of coverage because it involves a preexisting condition. The policy or certificate may 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 six months before the effective date of coverage;
 - (ii) a Medicare supplement policy or certificate must not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents;
 - (iii) a Medicare supplement policy or certificate must 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;
 - (iv) no Medicare supplement policy or certificate may 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;
 - (v) each Medicare supplement policy shall be guaranteed renewable and:
 - (A) the issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and
 - (B) the issuer shall not cancel or nonrenew the policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

- (vi) if the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under (1)(a)(viii), the issuer must offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):
 - (A) provides for continuation of the benefits contained in the group policy; or
 - (B) provides for such benefits that meet the requirements of this subsection.
 - (vii) if an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:
 - (A) offer the certificateholder the conversion opportunity described in (1)(a)(vi); or
 - (B) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.
 - (viii) 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 must not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.
- (2) Termination of a Medicare supplement policy or certificate must 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.
- (3) A Medicare supplement policy or certificate must provide that benefits and premiums under the policy or certificate must be suspended at the request of the policyholder or certificateholder for the period (not to exceed 24 months) in which the policyholder or certificateholder 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 certificateholder notifies the issuer of such policy or certificate within 90 days after the date the individual becomes entitled to such assistance. Upon receipt of timely notice, the issuer must either return to the policyholder or certificateholder that portion of the premium attributable to the period of Medicaid eligibility, or provide coverage to the end of the term for which premiums were paid, at the option of the insured, subject to adjustment for paid claims:
 - (a) if such suspension occurs and if the policyholder or certificateholder loses entitlement to such medical assistance, such policy or certificate must be automatically reinstituted effective as of the date of termination of such entitlement if the policyholder or certificateholder provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of the termination of entitlement;
 - (b) each Medicare supplement policy or certificate must provide that benefits and premiums under the policy must be suspended (for any period that may be provided by Federal regulation) at the request of the policyholder or certificateholder if the policyholder or certificateholder is entitled to benefits under 226(b) of the Social Security Act and is covered under a group health plan (as defined in 1862(b)(1)(A)(v) of the Social Security Act). If

suspension occurs and if the policyholder or certificateholder 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 or certificateholder provides notice of loss of coverage within 90 days after the date of loss of coverage;

- (c) reinstitution of coverages as described in (3)(a) and (b) must:
 - (i) not provide for any limitation with respect to treatment of preexisting conditions;
 - (ii) provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and
 - (iii) provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.
- (4) Standards for basic ("core") benefits common to benefit Plans A, B, C, D, F, F with High Deductible, G, M, and N include the following:
 - (a) every issuer 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 thereof:
 - (i) coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
 - (ii) coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
 - (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 any balance;
 - (iv) coverage under Medicare Parts A and B for 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;
 - (v) 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; and
 - (vi) coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
 - (b) The following additional benefits must be included in Medicare Supplement Benefit Plans B, C, D, F, and F with High Deductible, G, M, and N as provided by ARM 6.6.507E:
 - (i) coverage for 100% of the Medicare Part A inpatient hospital deductible amount per benefit period;

- (ii) coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period;
- (iii) 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;
- (iv) coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;
- (v) coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge; and
- (vi) 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 a 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.

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, MAR p. 1819, Eff. 10/18/13.