191—37.6(514D) Minimum benefit standards for prestandardized Medicare supplement benefit plan policies or certificates issued for delivery prior to January 1, 1992 (prestandardized plans). No policy or certificate may be advertised, solicited or issued for delivery in this state as a prestandardized plan policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

37.6(1) *General standards.* The following standards apply to prestandardized plans and are in addition to all other requirements of this chapter.

a. A prestandardized plan shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The prestandardized plan shall 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.

b. A prestandardized plan shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

c. A prestandardized plan shall 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.

d. A "noncancelable," "guaranteed renewable," or "noncancelable and guaranteed renewable" prestandardized plan shall not:

(1) Provide for termination of coverage of a spouse of a group member solely because of the occurrence of an event specified for termination of coverage of the group member, other than the nonpayment of premium; or

(2) Be canceled or nonrenewed by the issuer solely on the grounds of deterioration of health.

e. Except as authorized by the commissioner, an issuer shall neither cancel nor nonrenew a prestandardized plan policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

f. Group Medicare supplement policies.

(1) If a group prestandardized plan is terminated by the group policyholder and not replaced as provided in subparagraph 37.6(1)*"f"*(3), the issuer shall offer to each of the covered individuals under the group prestandardized plan an individual Medicare supplement policy. The issuer shall offer each of the group prestandardized plan's covered individuals at least the following choices:

1. An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group prestandardized plan; and

2. An individual Medicare supplement policy which provides only such benefits as are required to meet the basic core benefits minimum standards as defined in subrule 37.7(2).

(2) If a covered individual's membership with the group entity that is the group policyholder is terminated, the issuer shall:

1. Offer the covered individual such conversion opportunities as are described in subparagraph 37.6(1)*"f"*(1); or

2. At the option of the group policyholder, offer the covered individual continuation of coverage under the group prestandardized plan.

(3) If a group prestandardized plan is replaced by another group Medicare supplement policy purchased by the same group policyholder, the issuer of the replacement group Medicare supplement policy shall offer coverage to all covered individuals under the replaced group prestandardized plan on its date of termination. Coverage under the new replacement group Medicare supplement policy shall not result in any exclusion for preexisting conditions that would have been covered under the replaced group prestandardized plan.

(4) If a prestandardized plan eliminates an outpatient prescription drug benefit as a result of requirements imposed by the MMA, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subrule.

g. Termination of a prestandardized plan policy or certificate shall be without prejudice to any continuous loss which commenced while the prestandardized plan policy or certificate was in force, but the extension of benefits beyond the period during which the prestandardized plan policy or certificate was in force may be predicated upon the continuous total disability of the covered individual, limited to the duration of the prestandardized plan policy or certificate benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

37.6(2) *Minimum benefit standards.* The following are minimum benefit standards for prestandardized plans:

a. Coverage of Part A Medicare-eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;

b. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

c. Coverage of Part A Medicare-eligible expenses which are incurred as daily hospital charges during the covered individual's use of Medicare's lifetime hospital inpatient reserve days;

d. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

e. Coverage under Medicare Part A 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 or already paid for under Part B;

f. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a PPS, the copayment amount, of Medicare-eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible;

g. Effective January 1, 1990, coverage under Medicare Part 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 or already paid for under Part A, subject to the Medicare deductible amount.

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