191—37.7(514D) Benefit standards for 1990 standardized Medicare supplement benefit plan policies or certificates issued for delivery on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010 (1990 plans). The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after January 1, 1992, and with an effective date for coverage prior to 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 standards. No issuer may offer any prestandardized Medicare supplement benefit plan for sale on or after January 1, 1992. Benefit standards applicable to Medicare supplement policies and certificates issued before January 1, 1992, remain subject to the requirements of rule 191—37.6(514D).

37.7(1) *General standards.* The following standards apply to 1990 plans and are in addition to all other requirements of this chapter.

a. Combinations of benefits other than standard not allowed. 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 subrule 37.7(6) and in rule 191—37.20(514D).

b. Uniformity and conformity. All 1990 plans shall be uniform in structure, language, designation and format to the standardized Medicare supplement benefit plans A through L listed in subrule 37.7(4) and shall conform to the definitions in rules 191—37.3(514D) and 191—37.4(514D). Each benefit shall be structured in accordance with the format provided in this rule 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.

c. Other designations may be used. An issuer may use, in addition to the benefit plan designations required in paragraph 37.7(1)*"b,"* other designations to the extent permitted by law.

d. Preexisting conditions. A 1990 plan shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because the claim involved a preexisting condition. The 1990 plan 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.

e. Sickness same as accident. A 1990 plan shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

f. Automatic change of cost sharing. A 1990 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 deductible, copayment, or coinsurance amounts set by Medicare. Premiums may be modified to correspond with such changes.

g. Termination of coverage of spouse. No 1990 plan shall 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.

h. Guaranteed renewability. Each 1990 plan shall be guaranteed renewable.

(1) The issuer shall not cancel or nonrenew a 1990 plan solely on the ground of health status of the covered individual.

(2) The issuer shall not cancel or nonrenew a 1990 plan for any reason other than nonpayment of premium or material misrepresentation.

(3) If the 1990 plan is terminated by the group policyholder and is not replaced as provided under subparagraph 37.7(1)*"h"*(5), the issuer shall offer to the covered individual a conversion opportunity of an individual Medicare supplement policy which, at the option of the covered individual, either:

1. Provides for continuation of the benefits contained in the group 1990 plan; or

2. Provides for such benefits as otherwise meet the requirements of this subrule.

(4) If a covered individual under a group 1990 plan terminates membership in the group, the issuer shall either:

1. Offer the covered individual the conversion opportunity described in subparagraph 37.7(1)*"h"*(3); or

2. At the option of the group policyholder, offer the covered individual continuation of coverage under the group Medicare supplement policy.

(5) If a group 1990 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 under the replacement group Medicare supplement policy to all covered individuals of the replaced group 1990 plan effective on the date of termination of the replaced group 1990 plan. Coverage under the replacement group Medicare supplement policy shall not result in any exclusion of any covered individual's preexisting conditions that would have been covered under the replaced group 1990 plan.

(6) If a 1990 plan eliminates an outpatient prescription drug benefit as a result of requirements imposed by the MMA, the modified 1990 plan shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

i. Termination involving continuous loss. Termination of a 1990 plan shall be without prejudice to any continuous loss which commenced while the 1990 plan was in force, but the extension of benefits beyond the period during which the 1990 plan was in force may be conditioned upon the continuous total disability of the covered individual, limited to the duration of the 1990 plan 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.

j. Suspension for Title XIX coverage.

(1) A 1990 plan shall provide that benefits and premiums under the 1990 plan shall be suspended at the request of the covered individual for the period (not to exceed 24 months) in which the covered individual has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the covered individual notifies the issuer of such 1990 plan within 90 days after the date the covered individual becomes entitled to such assistance.

(2) If such suspension occurs and if the covered individual loses entitlement to such medical assistance, such 1990 plan shall be automatically reinstituted (effective as of the date of termination of such entitlement) if the covered individual 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 termination of such entitlement.

(3) Each 1990 plan shall provide that benefits and premiums under the 1990 plan shall be suspended for the period provided by federal regulation at the request of the covered individual if the covered individual is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan as defined in Section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the covered individual loses coverage under the group health plan, the 1990 plan shall be automatically reinstituted effective as of the date of loss of coverage if the covered individual provides notice to the issuer of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

(4) Reinstitution of coverage as described in subparagraphs 37.7(1)*"j"*(2) and (3):

1. Shall not provide for any waiting period with respect to treatment of preexisting conditions;

2. Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended 1990 plan provided coverage for outpatient prescription drugs, reinstitution of the 1990 plan for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

3. Shall provide for classification of premiums on terms at least as favorable to the covered individual as the premium classification terms that would have applied to the covered individual had the coverage not been suspended.

k. Exchange of 1990 plan to 2010 plan. If an issuer makes a written offer to a covered individual covered by one or more of the issuer's 1990 plans (as described in this rule) to allow, during a specified period, the covered individual to exchange coverage from the covered individual's 1990 plan (as described in this rule) to a 2010 plan (as described in rule 191—37.8(514D)), the offer and subsequent exchange shall comply with the following requirements:

(1) An issuer need not provide justification to the commissioner or comply with 191—Chapter 16 or rule 191—37.27(514D) if the covered individual exchanges a 1990 plan policy or certificate for an issue-age-rated 2010 plan policy or certificate using the same issue age and duration as was used for the covered individual's 1990 plan policy or certificate to be exchanged. If a covered individual's 1990 plan policy or certificate to be exchanged is priced on an issue-age-rate schedule at the time of such offer, the rate charged to the covered individual for the exchanged 2010 plan policy or certificate shall recognize the policy reserve buildup, due to the prefunding inherent in the use of an issue-age-rate basis, for the benefit of the covered individual. The rating method proposed to be used by an issuer must be filed with the commissioner pursuant to rule 191—37.24(514D).

(2) The rating class of the new exchanged 2010 plan policy or certificate shall be the class closest to the covered individual's rating class of the exchanged 1990 plan.

(3) An issuer may not apply new preexisting condition limitations or a new incontestability period to the covered individual's exchanged 2010 plan for those benefits contained in the exchanged 1990 plan, but may apply preexisting condition limitations of no more than six months to any added benefits contained in the exchanged 2010 plan that were not contained in the exchanged 1990 plan.

(4) The exchanged 2010 plan shall be offered to all covered individuals within a given 1990 plan, except where the offer or issue would be in violation of state or federal law.

37.7(2) *Standards for basic core benefits common to 1990 standardized Medicare supplement benefit plans A through J (1990 plans).* Every issuer shall make available a 1990 plan including only the following basic core benefits to each prospective covered individual. An issuer may make available to prospective covered individuals any of the issuer's other standardized Medicare supplement benefit plans in addition to the basic core benefits, but not in lieu thereof. The 1990 basic core benefits are the following:

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 of Part A Medicare-eligible expenses incurred for hospitalization, to the extent not covered by Medicare, for each Medicare lifetime inpatient reserve day used;

c. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization, paid at the applicable PPS rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. Medicare requires that the provider shall accept the issuer's payment as payment in full and that the provider may not bill the covered individual for any balance;

d. 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;

e. Coverage for the coinsurance amount or, in the case of hospital outpatient department services paid under a PPS, the copayment amount of Medicare Part B eligible expenses regardless of hospital confinement, subject to the Medicare Part B deductible.

37.7(3) *Standards for additional benefits for plans B through J.* The following benefit descriptions apply to the additional benefits specified for 1990 plans B through J in subrule 37.7(4):

a. Medicare Part A deductible: coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

b. Skilled nursing facility care: coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

c. Medicare Part B deductible: coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

d. Eighty percent of the Medicare Part B excess charges: coverage for 80 percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by Medicare or by state law, and the Medicare-approved Part B charge.

e. One hundred percent of the Medicare Part B excess charges: coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by Medicare or by state law, and the Medicare-approved Part B charge.

f. Basic outpatient prescription drug benefit: coverage for 50 percent of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 in benefits received by the covered individual per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare 1990 plan until January 1, 2006.

g. Extended outpatient prescription drug benefit: coverage for 50 percent of outpatient prescription drug charges, after a $250 calendar year deductible to a maximum of $3,000 in benefits received by the covered individual per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare 1990 plan until January 1, 2006.

h. Medically necessary emergency care in a foreign country: coverage to the extent not covered by Medicare for 80 percent 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.

i. Preventive medical care benefit:

(1) Coverage for the following preventive health services not covered by Medicare:

1. An annual clinical preventive medical history and physical examination that may include tests and services from numbered paragraph "2" and patient education to address preventive health care measures.

2. Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

(2) Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association current procedural terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

j. At-home recovery benefit: coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(1) For purposes of this benefit, the following definitions shall apply:

"Activities of daily living" includes, but is not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

"At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

"Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

"Home" shall mean any place used by the covered individual as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the covered individual's place of residence.

(2) Coverage requirements and limitations.

1. At-home recovery services provided must be primarily services which assist in activities of daily living.

2. The covered individual's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

3. Coverage is limited to:

- No more than the number and type of at-home recovery visits certified as necessary by the covered individual's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment.
- The actual charges for each visit up to a maximum reimbursement of $40 per visit.
- One thousand six hundred dollars per calendar year.
- Seven visits in any one week.
- Care furnished on a visiting basis in the covered individual's home.
- Services provided by a care provider as defined in this paragraph 37.7(3)*"j."*
- At-home recovery visits while the covered individual is covered under the policy or certificate and not otherwise excluded.
- At-home recovery visits received during the period the covered individual is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit.

(3) Coverage is excluded for:

1. Home care visits paid for by Medicare or other government programs; and
2. Care provided by family members, unpaid volunteers or providers who are not care providers.

37.7(4) *Elements required in standardized 1990 Medicare supplement benefit plans.* The additional benefits described in subrule 37.7(3) shall be included in 1990 Medicare supplement benefit plans as specified for each 1990 plan as follows:

a. Plan A shall be limited to the basic core benefits, as defined in subrule 37.7(2).

b. Plan B shall include only the following: basic core benefits as set forth in subrule 37.7(2), plus the Medicare Part A deductible as defined in paragraph 37.7(3)*"a."*

c. Plan C shall include only the following: basic core benefits as set forth in subrule 37.7(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in paragraphs 37.7(3)*"a,""b,""c,"* and *"h,"* respectively.

d. Plan D shall include only the following: basic core benefits as set forth in subrule 37.7(2), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs 37.7(3)*"a,""b,""h,"* and *"j,"* respectively.

e. Plan E shall include only the following: basic core benefits as set forth in subrule 37.7(2), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and preventive medical care as defined in paragraphs 37.7(3)*"a,""b,""h,"* and *"i,"* respectively.

f. Plan F shall include only the following: basic core benefits as set forth in subrule 37.7(2), plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.7(3)*"a,""b,""c,""e,"* and *"h,"* respectively.

g. Plan G shall include only the following: basic core benefits as set forth in subrule 37.7(2), plus the Medicare Part A deductible, skilled nursing facility care, 80 percent of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs 37.7(3)*"a,""b,""d,""h,"* and *"j,"* respectively.

h. Plan H shall consist of only the following: basic core benefits as set forth in subrule 37.7(2), plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit, and medically necessary emergency care in a foreign country as defined in paragraphs 37.7(3)*"a,""b,""f,"* and *"h,"* respectively. The outpatient prescription drug benefit shall not be included in a 1990 plan sold after December 31, 2005.

i. Plan I shall consist of only the following: basic core benefits as set forth in subrule 37.7(2), plus the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in paragraphs 37.7(3)*"a,""b,""e,""f,""h,"* and *"j,"* respectively.

The outpatient prescription drug benefit shall not be included in a 1990 plan sold after December 31, 2005.

j. Plan J shall consist of only the following: basic core benefits as set forth in subrule 37.7(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in paragraphs 37.7(3)*"a,""b,""c,""e,""g,""h,""i,"* and *"j,"* respectively. The outpatient prescription drug benefit shall not be included in a 1990 plan sold after December 31, 2005.

k. High deductible Plan F shall include only the following: 100 percent of covered expenses following the payment of the annual high deductible Plan F deductible. The covered expenses include the basic core benefits as set forth in subrule 37.7(2), plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.7(3)*"a,""b,""c,""e,"* and *"h,"* respectively. The annual high deductible Plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Plan F policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan F deductible shall be $1,500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter 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.

l. High deductible Plan J shall consist of only the following: 100 percent of covered expenses following the payment of the annual high deductible Plan J deductible. The covered expenses include the basic core benefits as set forth in subrule 37.7(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit, and at-home recovery benefit as defined in paragraphs 37.7(3)*"a,""b,""c,""e,""g,""h,""i,"* and *"j,"* respectively. The annual high deductible Plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan J policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1,500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter 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. The outpatient prescription drug benefit shall not be included in a 1990 plan sold after December 31, 2005.

m. Plan K shall consist of the following:

(1) Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the sixty-first day through the ninetieth day in any Medicare benefit period;

(2) Coverage of 100 percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first day through the one hundred fiftieth day in any Medicare benefit period;

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable 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 in full and may not bill the covered individual for any balance;

(4) Medicare Part A deductible: coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph 37.7(4)*"m"*(10);

(5) Skilled nursing facility care: coverage for 50 percent of the coinsurance amount for each day used from the twenty-first day through the one hundredth 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 subparagraph 37.7(4)*"m"*(10);

(6) Hospice care: coverage for 50 percent of cost sharing for all Part A Medicare-eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph 37.7(4)*"m"*(10);

(7) Coverage for 50 percent, 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 subparagraph 37.7(4)*"m"*(10);

(8) Except for coverage provided in subparagraph 37.7(4)*"m"*(9), coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the covered individual pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph 37.7(4)*"m"*(10);

(9) Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the covered individual pays the Part B deductible; and

(10) Coverage of 100 percent 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 $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary.

n. Plan L shall consist of the following:

(1) The benefits described in subparagraphs 37.7(4)*"m"*(1), (2), (3), and (9);

(2) The benefits described in subparagraphs 37.7(4)*"m"*(4), (5), (6), (7) and (8), but substituting 75 percent for 50 percent in each subparagraph; and

(3) The benefit described in paragraph 37.7(4)*"m"*(10), but substituting $2,000 for $4,000.

37.7(5) *Elements required in Medicare supplement plans mandated by the MMA.* The 1990 plans mandated by the MMA, Plans K and L, shall include the benefits described for each plan, as follows:

a. Plan K mandated by the MMA shall consist of only those benefits described in paragraph 37.7(4)*"m."*

b. Plan L mandated by the MMA shall consist of only those benefits described in paragraph 37.7(4)*"n."*

37.7(6) *New or innovative benefits.* An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

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