191—37.8(514D) 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 (2010 plans). 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 was to be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate during that time period unless it complied with the benefit standards set forth in this rule. 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 before June 1, 2010, remain subject to the requirements of rule 191—37.6(514D) or 191—37.7(514D).

37.8(1) *General standards.* The following standards apply to 2010 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 37.8(5) and rule 191—37.20(514D).

b. Uniformity and conformity. All 2010 plans shall be uniform in structure, language, designation and format to the standardized benefit plans listed in subrule 37.8(4), and shall conform to the definitions in rules 191—37.3(514D) and 191—37.4(514D). Each benefit plan shall be structured in accordance with the format provided in subrules 37.8(2), 37.8(3) and 37.8(4), or in the case of Plan K or L, each benefit plan shall be structured in accordance with the format provided in paragraph 37.8(4)*"h"* or *"i."* Each plan shall list the benefits in the order shown. 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 37.8(1)*"b,"* other designations to the extent permitted by law.

d. Preexisting conditions. A 2010 plan shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because the losses involved a preexisting condition. The 2010 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 2010 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 2010 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.

g. Termination of coverage of spouse. No 2010 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 named insured or group member, other than the nonpayment of premium.

h. Guaranteed renewability. Each 2010 plan shall be guaranteed renewable.

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

(2) The issuer shall not cancel or nonrenew the 2010 plan for any reason other than nonpayment of premium or material misrepresentation.

(3) If a group 2010 plan is terminated by the group policyholder and is not replaced as provided under subparagraph 37.8(1)*"h"*(5), the issuer shall offer covered individuals a conversion opportunity to an individual 2010 plan which, at the option of the covered individual, either:

1. Provides for continuation of the benefits contained in the group 2010 plan; or

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

(4) If a covered individual under a group 2010 plan terminates membership in the group, the issuer shall:

1. Offer the covered individual the conversion opportunity described in subparagraph 37.8(1)*"h"*(3); or

2. At the option of the group policyholder, offer the covered individual continuation of coverage under the group 2010 plan.

(5) If a group 2010 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 2010 plan on the effective date of termination of the replaced group 2010 plan. Coverage under the replacement group Medicare supplement policy shall not result in any exclusion for any covered individual's preexisting conditions that would have been covered under the replaced group 2010 plan.

i. Termination involving continuous loss. Termination of a 2010 plan policy or certificate shall be without prejudice to any continuous loss which commenced while the policy or certificate was in force, but the extension of benefits beyond the period during which the policy or certificate was in force may be conditioned upon the continuous total disability of the covered individual, limited to the duration of the policy or certificate 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 2010 plan shall provide that benefits and premiums under the policy or certificate 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 the policy or certificate within 90 days after the date the covered individual becomes entitled to assistance.

(2) If such suspension occurs and if the covered individual loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted effective as of the date of termination of entitlement if the covered individual provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(3) Each 2010 plan shall provide that benefits and premiums under the 2010 plan shall be suspended (for any period that may be 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 2010 plan policy or certificate 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 the loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

(4) Reinstitution of coverage as described in subparagraphs 37.8(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; 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.

37.8(2) *Standards for basic core benefits common to 2010 standardized Medicare supplement benefit Plans A, B, C, D, F, F with high deductible, G, M, and N (2010 basic core benefits).*

a. Availability of basic core benefits required. Every issuer of 2010 plans shall make available to each prospective covered individual a 2010 plan including only the following 2010 basic core benefits. An issuer may make available to a prospective covered individual any of the issuer's other Medicare supplement benefit plans in addition to the 2010 plan of basic core benefits, but not in lieu thereof.

b. When issuer must make certain plans available. If an issuer makes available any of the additional benefits described in subrule 37.8(3) or offers standardized benefit Plans K or L (as described in paragraphs 37.8(4)*"h"* and *"i"*), then the issuer shall make available to each prospective covered individual, in addition to a policy form or certificate form with only the 2010 plan basic core benefits as set forth in paragraph 37.8(2)*"c,"* a policy form or certificate form containing either standardized

benefit Plan C (as described in paragraph 37.8(4)*"c"*) or a standardized benefit Plan F (as described in paragraph 37.8(4)*"e"*).

c. *2010 plan basic core benefits.* The 2010 plan basic core benefits shall include the following:

(1) Hospitalization days 61 through 90: 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;

(2) Hospitalization for reserve days: 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;

(3) Hospitalization for additional 365 days: 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;

(4) Blood: 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;

(5) Coinsurance: 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 the Medicare Part B deductible; and

(6) Hospice care: coverage of cost sharing for all Part A Medicare-eligible hospice care and respite care expenses.

37.8(3) *Standards for 2010 plan additional benefits.* The following additional benefits shall be included in 2010 plan Plans B, C, D, F, F with high deductible, G, M, and N as provided by subrule 37.8(4):

a. Medicare Part A deductible: coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

b. Medicare Part A deductible: coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

c. 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;

d. Medicare Part B deductible: coverage for 100 percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;

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

f. 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.

37.8(4) *Elements required in standardized 2010 Medicare supplement benefit plans.* The 2010 plans shall include the benefits, as described for each plan, as follows:

a. Plan A shall include only the following: the basic core benefits as set forth in subrule 37.8(2).

b. Plan B shall include only the following: the basic core benefits as set forth in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible as defined in paragraph 37.8(3)*"a."*

c. Plan C shall include only the following: the basic core benefits as set forth in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the

Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"a,""c,""d,"* and *"f,"* respectively.

d. Plan D shall include only the following: the basic core benefits as set forth in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"a,""c,"* and *"f,"* respectively.

e. Plan F shall include only the following: the basic core benefits as set forth in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of 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 37.8(3)*"a,""c,""d,""e,"* and *"f,"* respectively.

f. Plan F with high deductible.

(1) Plan F with high deductible shall include only the following:

1. One hundred percent of covered expenses following the payment of the annual deductible set forth in subparagraph 37.8(4)*"f"*(2).

2. The basic core benefits as set forth in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of 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 37.8(3)*"a,""c,""d,""e,"* and *"f,"* respectively.

(2) The annual deductible in Plan F with high deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by (regular) Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be $1,500 and shall 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. Plan G shall include only the following: the core benefits as set forth in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"a,""c,""e,"* and *"f,"* respectively.

h. Plan K is mandated by the MMA and shall include only the following:

(1) Medicare Part A hospital coinsurance from the sixty-first day through the ninetieth day: 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) Medicare Part A hospital coinsurance from the ninety-first day through the one hundred fiftieth day: 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) Medicare Part A hospitalization after lifetime reserve days are exhausted: 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 as 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 37.8(4)*"h"*(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 37.8(4)*"h"*(10);

(6) Hospice care: coverage for 50 percent of cost sharing for all Medicare Part A eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph 37.8(4)*"h"*(10);

(7) Blood: 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 37.8(4)*"h"*(10);

(8) Medicare Part B cost sharing: except for coverage provided in subparagraph 37.8(4)*"h"*(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 37.8(4)*"h"*(10);

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

(10) Cost sharing after out-of-pocket limits reached: 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.

i. Plan L is mandated by the MMA and shall include only the following:

(1) The benefits described in subparagraphs 37.8(4)*"h"*(1), (2), (3) and (9);

(2) The benefits described in subparagraphs 37.8(4)*"h"*(4), (5), (6), (7) and (8), but substituting 75 percent for 50 percent; and

(3) The benefit described in subparagraph 37.8(4)*"h"*(10), but substituting $2,000 for $4,000.

j. Plan M shall include only the following: the basic core benefits as set forth in subrule 37.8(2), plus 50 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"b," "c,"* and *"f,"* respectively.

k. Plan N shall include only the following: the basic core benefits as set forth in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"a," "c,"* and *"f,"* respectively, with copayments in the following amounts:

(1) The lesser of $20 or the Medicare Part B coinsurance or copayment for each covered provider office visit (including visits to medical specialists); and

(2) The lesser of $50 or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the covered individual is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

37.8(5) *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 standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

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