WAC 284-66-063 Benefit standards for policies or certificates issued or delivered after June 30, 1992 and before 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.

(1) General standards. The following standards apply to medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(a) A medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than three months from the effective date of coverage because it involved 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 three months before the effective date of coverage.

(b) 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.

(c) A medicare supplement policy or certificate may not 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.

(d) Each medicare supplement policy must be guaranteed renewable and:

(i) The issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(ii) The issuer may not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(iii) If the medicare supplement policy is terminated by the group policyholder and is not replaced as provided under (d)(v) of this subsection, the issuer must offer certificate holders an individual medicare supplement policy that (at the option of the certificate holder) provides for continuation of the benefits contained in the group policy, or provides for benefits that otherwise meet the requirements of this subsection.

(iv) If an individual is a certificate holder in a group medicare supplement policy and the individual terminates membership in the group, the issuer must offer the certificate holder the conversion opportunity described in (c)(iii) of this subsection, or at the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(v) 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 must offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy may not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(e) Termination of a medicare supplement policy or certificate must be without prejudice to any continuous loss that began while the policy was in force, but the extension of benefits beyond the period that 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.

(f) If a medicare supplement policy or certificate eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug Improvement and Modernization Act of 2003, the modified policy or certificate is deemed to satisfy the guaranteed renewal requirements of this section.

(g)(i) 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 certificate holder for the period (not to exceed twenty-four months) that the policyholder or certificate holder 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 certificate holder notifies the issuer of the policy or certificate within ninety days after the date the individual becomes entitled to the assistance.

(ii) If the suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate must be automatically reinstituted effective as of the date of termination of the entitlement if the policyholder or certificate holder provides notice of loss of the entitlement within ninety days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(iii) Each medicare supplement policy must provide that benefits and premiums under the policy will be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder 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 policyholder or certificate holder loses coverage under the group health plan, the policy must be automatically reinstituted (effective as of the date of loss of coverage within ninety days after the date of the loss).

(h) Reinstitution of the coverages:

(i) May not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Must provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of the suspension. If the suspended medicare supplement policy or certificate provided coverage for outpatient prescription drugs, reinstitution of the policy for medicare Part D enrollees must be without coverage for outpatient prescription drugs and must otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(iii) Must provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(2) If an issuer makes a written offer to the medicare supplement policyholders or certificate holders of one or more of its plans, to exchange his or her standardized plan to a 2010 standardized plan during a specified period, the offer and subsequent exchange must comply with the following requirements:

(a) An issuer need not provide justification to the commissioner if the insured exchanges a 1990 standardized policy or certificate with a 2010 standardized policy or certificate.

(b) An issuer may not apply new preexisting condition limitations or a new incontestability period to the new 2010 standardized policy for those benefits contained in the former exchanged policy or certificate of the insured, but may apply preexisting condition limitations of no more than three months to any benefits contained in the new 2010 standardized policy or certificate that were not contained in the former exchanged policy.

(c) The new policy or certificate must be offered to all policyholders or certificate holders within a given plan, except where the offer or issue would be in violation of state or federal law.

(3) Standards for basic ("core") benefits common to benefit plans A-J. Every issuer must 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 place of the basic "core" package.

(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 one hundred percent 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 three hundred sixty-five days. The provider must accept the issuer's payment as payment in full and may not bill the insured 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 prospective payment system, the copayment amount, of medicare eligible expenses under Part B regardless of hospital confinement, subject to the medicare Part B deductible;

(4) Standards for additional benefits. The following additional benefits must be included in medicare supplement benefit plans "B" through "J" only as provided by WAC 284-66-066.

(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 posthospital 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 eighty percent 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.

(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 the medicare program or state law, and the medicare-approved Part B charge.

(f) Basic outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible, to a maximum of one thousand two hundred fifty dollars in benefits received by the insured per calendar year, to the extent not covered by medicare. The outpatient prescription drug benefit may not be included for sale or issuance in a medicare supplement policy after December 31, 2005.

(g) Extended outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible to a maximum of three thousand dollars in benefits received by the insured per calendar year, to the extent not covered by medicare. The outpatient prescription drug benefit may not be included for sale or issuance in a medicare supplement policy after December 31, 2005.

(h) Medically necessary emergency care in a foreign country: Coverage to the extent not covered by medicare for eighty percent of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, that would have been covered by medicare if provided in the United States and that began during the first sixty consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars, and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

(i) Preventive medical care benefit: Coverage for the following preventive health services not covered by medicare:

(i) An annual clinical preventive medical history and physical examination that may include tests and services from (ii) of this subsection and patient education to address preventive health care measures.

(ii) Preventive screening tests or preventive services, the selection and frequency that is determined to be medically appropriate by the attending physician.

Reimbursement must be for the actual charges up to one hundred 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 one hundred twenty dollars annually under this benefit. This benefit may 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.

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

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

(B) "Care provider" means a duly qualified or licensed home health aide/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.

(C) "Home" means any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by medicare. A hospital or skilled nursing facility is not considered the insured's place of residence.

(D) "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 twenty-four hour period of services provided by a care provider is one visit.

(ii) Coverage requirements and limitations.

(A) At-home recovery services provided must be primarily services that assist in activities of daily living.

(B) The insured'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.

(C) Coverage is limited to:

(I) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits may not exceed the number of medicare approved home health care visits under a medicare approved home care plan of treatment.

(II) The actual charges for each visit up to a maximum reimbursement of forty dollars per visit.

(III) One thousand six hundred dollars per calendar year.

(IV) Seven visits in any one week.

(V) Care furnished on a visiting basis in the insured's home.

(VI) Services provided by a care provider as defined in this section.

(VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

(VIII) At-home recovery visits received during the period the insured 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.

(iii) Coverage is excluded for: Home care visits paid for by medicare or other government programs; and care provided by family members, unpaid volunteers, or providers who are not care providers.

(5) Standardized medicare supplement benefit plan "K" must consist of the following:

(a) Coverage of one hundred percent of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any medicare benefit period;

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

(c) Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent 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 three hundred sixty-five days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Medicare Part A deductible: Coverage for fifty percent of the medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in (j) of this subsection;

(e) Skilled nursing facility care: Coverage for fifty 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 (j) of this subsection;

(f) Hospice care: Coverage for fifty 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 (j) of this subsection;

(g) Coverage for fifty 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 regulation) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in (j) of this subsection;

(h) Except for coverage provided in (i) of this subsection, coverage for fifty percent of the cost sharing otherwise applicable under medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in (j) of this subsection;

(i) Coverage of one hundred percent of the cost sharing for medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) Coverage of one hundred 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 four thousand dollars in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(6) Standardized medicare supplement benefit plan "L" must consist of the following:

(a) The benefits described in subsection (4)(a), (b), (c) and (i) of this section;

(b) The benefit described in subsection (4)(d), (e), (f) and (h) of this section but substituting seventy-five percent for fifty percent; and

(c) The benefit described in subsection (4)(j) of this section but substituting two thousand dollars for four thousand dollars.

[Statutory Authority: RCW 48.02.060(3) and 48.66.165. WSR 11-17-077 (Matter No. R 2010-11), § 284-66-063, filed 8/16/11, effective 9/16/11. Statutory Authority: RCW 48.66.030 (3)(a), 48.66.041, and 48.66.165. WSR 09-24-052 (Matter No. R 2009-08), § 284-66-063, filed 11/24/09, effective 1/19/10. Statutory Authority: RCW 48.06.060 and 48.66.165. WSR 07-06-014 (Matter No. R 2006-13), § 284-66-063, filed 2/26/07, effective 3/29/07. Statutory Authority: RCW 48.02.060 and 48.66.165. WSR 05-17-019 (Matter No. R 2004-08), § 284-66-063, filed 8/4/05, effective 9/4/05. Statutory Authority: RCW 48.02.060, 48.66.041 and 48.66.165. WSR 96-09-047 (Matter No. R 96-2), § 284-66-063, filed 4/11/96, effective 5/12/96. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.20.470, 48.30.010, 48.44.020, 48.44.050, 48.44.070, 48.46.030, 48.46.130 and 48.46.200. WSR

92-06-021 (Order R 92-1), § 284-66-063, filed 2/25/92, effective 3/27/92.]