

TITLE 50: INSURANCE
PART 2008 MINIMUM STANDARDS FOR INDIVIDUAL AND GROUP MEDICARE SUPPLEMENT
INSURANCE
CHAPTER I: DEPARTMENT OF INSURANCE
SECTION 2008.71 BENEFIT STANDARDS FOR POLICIES OR CERTIFICATES ISSUED OR

Section 2008.71 Benefit Standards for Policies or Certificates Issued or Delivered on or After the Effective Date of this Part

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this State on or after the effective date of this Part. 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.

- b) Standards for Basic ("Core") Benefits Common to Benefit Plans A-J
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.
- 1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
 - 2) 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) 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;
 - 4) Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;
 - 5) 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.
- c) Standards for Additional Benefits
The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Section 2008.72 of this Part.
- 1) Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.
 - 2) Skilled Nursing Facility Care: 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 posthospital skilled nursing facility care eligible under Medicare Part A.

- 3) Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.
- 4) Eighty Percent of the Medicare Part B Excess Charges: Coverage for 80% 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.
- 5) 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.
- 6) Basic Outpatient Prescription Drug Benefit: Coverage for 50% of outpatient prescription drug charges, after a \$250 calendar year deductible, to a maximum of \$1,250 in benefits received by the insured 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 supplement policy until January 1, 2006.
- 7) Extended Outpatient Prescription Drug Benefit: Coverage for 50% of outpatient prescription drug charges, after a \$250 calendar year deductible to a maximum of \$3,000 in benefits received by the insured 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 supplement policy until January 1, 2006.
- 8) Medically Necessary Emergency Care in a Foreign Country: 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 illness of sudden and unexpected onset.
- 9) Preventive Medical Care Benefit: Coverage for the following preventive health services not covered by Medicare:
 - A) An annual clinical preventive medical history and physical examination that may include tests and services from subsection (c)(9)(B) and patient education to address preventive health care measures; and
 - B) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician;
 - C) Reimbursement shall be for the actual charges up to 100% 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.

10) 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.

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

- i) "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.
- ii) "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.
- iii) "Home" shall mean any place used by the insured 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 insured's place of residence.
- iv) "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 4 hours in a 24-hour period of services provided by a care provider is one visit.

B) Coverage Requirements and Limitations

- i) At-home recovery services provided must be primarily services which assist in activities of daily living.
- ii) 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.
- iii) Coverage is limited to:
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 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.

\$1,600 per calendar year.

7 visits in any one week.

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

Services provided by a care provider as defined in this Section.

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

At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than 8 weeks after the service date of the last Medicare approved home health care visit.

- C) Coverage is excluded for:
 - i) Home care visits paid for by Medicare or other government programs; and
 - ii) Care provided by family members, unpaid volunteers or providers who are not care providers.

(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)