

TITLE 50: INSURANCE
PART 2008 MINIMUM STANDARDS FOR INDIVIDUAL AND GROUP MEDICARE SUPPLEMENT
INSURANCE
CHAPTER I: DEPARTMENT OF INSURANCE

Section 2008.APPENDIX L Plan J or High Deductible Plan J**

MEDICARE (PART A) – Hospital Services – Per Benefit Period

Companies must add the current fixed dollar amount authorized by Medicare where the brackets appear below. The dollar amount is updated periodically by Medicare and companies must reflect these changes to their outlines of coverage in a timely manner.

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[** This high deductible plan pays the same benefits as Plan J after one has paid a calendar year [\$_____] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are [\$_____]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

| SERVICES | MEDICARE PAYS | [AFTER YOU PAY [\$_____] DEDUCTIBLE**] PLAN PAYS | [IN ADDITION TO [\$_____] DEDUCTIBLE**] YOU PAY |
|---|---------------------------|---|--|
| HOSPITALIZATION* | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but [\$_____] | [\$_____] (Part A Deductible) | \$0 |
| 61st thru 90th day | All but [\$_____] a day | [\$_____] a day | \$0 |
| 91st day and after; | | | |
| - While using 60 lifetime reserve days | All but [\$_____] a day | [\$_____] a day | \$0 |
| - Once lifetime reserve days are used: | | | |
| - Additional 365 days | \$0 | 100% of Medicare Eligible Expenses | \$0*** |
| - Beyond the Additional 365 days | \$0 | \$0 | All costs |
| SKILLED NURSING FACILITY CARE* | | | |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | \$0 | \$0 |

| | | | |
|---|---|------------------------|-----------|
| 21st thru 100th day | All but [\$ _____] a day | Up to [\$ _____] a day | \$0 |
| 101st day and after | \$0 | \$0 | All costs |
| BLOOD | | | |
| First 3 pints | \$0 | 3 pints | \$0 |
| Additional amounts | 100% | \$0 | \$0 |
| HOSPICE CARE | | | |
| Available as long as your doctor certifies you are terminally ill and you elect to receive these services | All but very limited co-insurance for out-patient drugs and in-patient respite care | \$0 | Balance |

***Notice When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid."

(Plan J or High Deductible Plan J Continued)

MEDICARE (PART B) – Medical Services – Per Calendar Year

*Once you have been billed \$[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as Plan J after one has paid a calendar year [\$____] deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are [\$____]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate outpatient prescription drug deductible or the plan's separate foreign travel emergency deductible.]

| SERVICES | MEDICARE PAYS | [AFTER YOU PAY [\$____] DEDUCTIBLE**] PLAN PAYS | [IN ADDITION TO [\$____] DEDUCTIBLE**] YOU PAY |
|---|---------------|---|---|
| MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | | | |
| First \$[100] of Medicare Approved Amounts* | \$0 | \$[100] (Part B Deductible) | \$0 |
| Remainder of Medicare Approved Amounts | generally 80% | generally 20% | \$0 |

| | | | |
|---|------|-----------------------------|-----|
| Part B Excess Charges (Above Medicare Approved Amounts) | \$0 | 100% | \$0 |
| BLOOD | | | |
| First 3 pints | \$0 | All costs | \$0 |
| Next \$[100] of Medicare Approved Amounts* | \$0 | [\$100] (Part B Deductible) | \$0 |
| Remainder of Medicare Approved Amounts | 80% | 20% | \$0 |
| CLINICAL LABORATORY SERVICES-TESTS FOR DIAGNOSTIC SERVICES | 100% | \$0 | \$0 |

PARTS A & B

| SERVICES | MEDICARE PAYS | [AFTER YOU PAY [\$___] DEDUCTIBLE**] PLAN PAYS | [IN ADDITION TO [\$___] DEDUCTIBLE**] YOU PAY |
|---|---------------|---|---|
| HOME HEALTH CARE | | | |
| MEDICARE APPROVED SERVICES | | | |
| - Medically necessary skilled care services and medical supplies | 100% | \$0 | \$0 |
| - Durable medical equipment | | | |
| First \$[100] of Medicare Approved Amounts* | \$0 | [\$100] (Part B Deductible) | \$0 |
| Remainder of Medicare Approved Amounts | 80% | 20% | \$0 |
| AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE | | | |
| Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan | | | |
| - Benefit for each visit | \$0 | Actual charges to \$40 a visit | Balance |
| - Number of visits covered (must be received within 8 weeks of last Medicare Approved visit) | \$0 | Up to the number of Medicare Approved visits, not to exceed 7 each week | |
| - Calendar year maximum | \$0 | \$1,600 | |

OTHER BENEFITS – NOT COVERED BY MEDICARE

| SERVICES | MEDICARE PAYS | [AFTER YOU PAY [\$___] DEDUCTIBLE**] PLAN | [IN ADDITION TO [\$___] DEDUCTIBLE**] YOU PAY |
|----------|---------------|--|--|
|----------|---------------|--|--|

| | | PAYS | |
|---|------------|--|---|
| FOREIGN TRAVEL-NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges | \$0 \$0 | \$0 80% to a lifetime maximum benefit of \$50,000 | \$250 20% and amounts over the \$50,000 lifetime maximum |
| | | | |
| ***PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional charges | \$0 \$0 | \$120 \$0 | \$0 All costs |

*** Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

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