

**TITLE 50: INSURANCE**  
**PART 2008 MINIMUM STANDARDS FOR INDIVIDUAL AND GROUP MEDICARE SUPPLEMENT**  
**INSURANCE**  
**CHAPTER 1: DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION**

**Section 2008.APPENDIX N Plan L**

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.

- \* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[ ] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**MEDICARE (PART A) – HOSPITAL SERVICES-PER BENEFIT PERIOD**

\*\* 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>HOSPITALIZATION**</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$[ ]	\$[ ] (75% of Part A deductible)	\$[ ] (25% of Part A deductible)♦
61 <sup>st</sup> 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

<b>SKILLED NURSING FACILITY CARE**</b> 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 21st thru 100th day 101st day and after	All approved amounts  All but \$[ ] a day  \$0	\$0  Up to \$[ ] a day  \$0	\$0  Up to \$[ ] a day♦  All costs
<b>BLOOD</b>  First 3 pints Additional amounts	\$0  100%	75%  \$0	25% ♦  \$0
<b>HOSPICE CARE</b>  Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments ♦

\*\*\* **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 L**

**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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>MEDICAL EXPENSES –</b> 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****  Preventive Benefits for Medicare covered services	\$0   Generally 75% or more of Medicare approved amounts	\$0   Remainder of Medicare approved amounts	\$[100] (Part B deductible)**** ♦   All costs above Medicare approved amounts

Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$_____])*
<b>BLOOD</b> First 3 pints	\$0	75%	25% ♦
Next \$[100] of Medicare Approved Amounts****	\$0	\$0	\$[100] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

\* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[ ] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

## PLAN L

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment 1st \$[100] of Medicare Approved Amounts****	\$0	\$0	\$[100] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	15%	5% ♦

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

(Source: Appendix N renumbered to Appendix S; new Appendix N added at 29 Ill. Reg. 14188, effective September 8, 2005)