**Section 2008.71 Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery after February 11, 1992 and Prior to June 1, 2010**

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this State on or after February 11, 1992 and with an effective date for coverage prior to 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.

a) General Standards

The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Part.

1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage because the losses involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than as a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

3) A Medicare supplement policy or certificate 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.

4) No Medicare supplement policy or certificate shall 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.

5) Each Medicare supplement policy shall be guaranteed renewable and:

A) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual;

B) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation;

C) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subsection (a)(5)(E), the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):

i) Provides for continuation of the benefits contained in the group policy, or

ii) Provides for such benefits as otherwise meet the requirements of this subsection;

D) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

i) Offer the certificateholder the conversion opportunity described in subsection (a)(5)(C), or

ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy;

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

F) If a Medicare supplement policy 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 shall be deemed to satisfy the guaranteed renewal requirements of this subsection (a)(5).

6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which 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.

7) A Medicare supplement policy or certificate shall provide:

A) That benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed 24 months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act (42 USC 1901-1941), but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within 90 days after the date the individual becomes entitled to such assistance.

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

C) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall 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 (42 USC 426(b)) and is covered under a group health plan as defined in section 1862(b)(1)(A)(v) of the Social Security Act (42 USC 1395y(b)(1)(A)(v)). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of such coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of such loss.

D) Reinstitution of such coverages as described in subsections (a)(7)(B) and (C):

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

ii) Shall 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 provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

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

8) If, after June 1, 2010, an issuer makes a written offer to the Medicare Supplement policyholders or certificateholders of one or more of its plans, to exchange during a specified period from his or her 1990 Standardized plan (as described in Section 2008.72 of this Part) to a 2010 Standardized plan (as described in Section 2008.67 of this Part), the offer and subsequent exchange shall comply with the following requirements:

A) An issuer need not provide justification to the Director if the insured replaces a 1990 Standardized policy or certificate with an issue age rated 2010 Standardized policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the Director.

B) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.

C) An issuer may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 Standardized policy or certificate of the insured, but may apply pre-existing condition limitations of no more than 6 months to any added benefits contained in the new 2010 Standardized policy or certificate not contained in the exchanged policy.

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

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;

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.

d) Standards for Plans K and L

1) Standardized Medicare supplement benefit Plan "K" shall consist of the following:

A) Coverage of 100% of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

B) Coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

C) 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;

D) Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subsection (d)(1)(J);

E) Skilled Nursing Facility Care: Coverage for 50% of the coinsurance amount for each day used from the 21st day through the 100th 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 subsection (d)(1)(J);

F) Hospice Care: Coverage for 50% of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subsection (d)(1)(J);

G) Coverage for 50%, under Medicare Part A or B, of 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 until the out-of-pocket limitation is met as described in subsection (d)(1)(J);

H) Except for coverage provided in subsection (d)(1)(J), coverage for 50% 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 subsection (d)(1)(J);

I) Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

J) Coverage of 100% 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 $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

2) Standardized Medicare supplement benefit Plan "L" shall consist of the following:

A) The benefits described in subsections (d)(1)(A), (B), (C) and (J);

B) The benefits described in subsections (d)(1)(D), (E), (F), (G) and (H), but substituting 75% for 50%; and

C) The benefit described in subsection (d)(1)(J), but substituting $2000 for $4000.

(Source: Amended at 33 Ill. Reg. 8904, effective June 10, 2009)