**20:06:13:17.04.  Standards for additional benefits for 1990 standardized Medicare supplement benefit plans.** The following additional benefits must be included in Medicare supplement benefit Plans B to J, inclusive, as described in § 20:06:13:17.06, issued for delivery after July 16, 1992, and prior to June 1, 2010:

(1)  Medicare Part A deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount for each 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 for each calendar year regardless of hospital confinement;

(4)  Eighty percent of the Medicare Part B excess charges: Coverage for 80 percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program, 42 U.S.C. § 1395 et seq, as in effect on July 1, 1999, and the Medicare-approved Part B charge, 42 U.S.C. § 1395 et seq, as in effect on July 1, 1999;

(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, 42 U.S.C. § 1395 et seq, as in effect on July 1, 1999, and the Medicare-approved Part B charge, 42 U.S.C. § 1395 et seq, as in effect on July 1, 1999;

(6)  Basic outpatient prescription drug benefit: Coverage for 50 percent of outpatient prescription drug charges, after a deductible for each calendar year of $250, to a maximum of $1,250 in benefits received by the insured for each calendar year to the extent not covered by Medicare. The basic 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 percent of outpatient prescription drug charges, after a deductible for each calendar year of $250, to a maximum of $3,000 in benefits received by the insured for each calendar year to the extent not covered by Medicare. The extended 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 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, if the care would have been covered by Medicare if provided in the United States and if the care began during the first 60 consecutive days of each trip outside the United States, subject to a deductible for each calendar year of $250 and a lifetime maximum benefit of $50,000. For purposes of this benefit, the term, emergency care, means care needed immediately because of an injury or an 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 subdivision (9)(b) of this section and patient education to address preventive health care measures;

(b)  Preventive screening tests or preventive services, the selection and frequency of which is considered medically appropriate by the attending physician.

Reimbursement shall be for the actual charges to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in **Current Procedural Coding Expert, 2008**, as published by the American Medical Association, to a maximum of $120 annually under this benefit. This benefit may 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. Requirements for this benefit are as follows:

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

(i)    "Activities of daily living," including bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings;

(ii)   "Care provider," 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. A home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency, referral agency, or nurses' registry is considered licensed pursuant to this section if qualified for Medicare reimbursement pursuant to 42 U.S.C. § 1395 et seq, as in effect on July 1, 1999;

(iii)  "Home," any place used by the insured as a place of residence, if that 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, 42 U.S.C. § 1395, et seq, as in effect on July 1, 1999;

(iv)   "At-home recovery visit," the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except that each consecutive four hours in a 24-hour period of services provided by a care provider is one visit;

(b)  Coverage requirements for this benefit are as follows:

(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;

(c)  Coverage limits for this benefit are as follows:

(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 $40 a visit;

(iii)    One thousand six hundred dollars for each 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; and

(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;

(d)  Coverage is excluded for the following:

(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;

(11)  New or innovative benefits: An issuer may, with the prior approval of the director, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. Such new or innovative benefits may include benefits that are applicable to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit may not include an outpatient prescription drug benefit.

**Source:** 18 SDR 225, effective July 17, 1992; 19 SDR 160, effective April 27, 1993; 22 SDR 107, effective February 18, 1996; 26 SDR 26, effective September 1, 1999; 27 SDR 53, 27 SDR 54, effective December 4, 2000; 30 SDR 39, effective September 28, 2003; 31 SDR 214, effective July 6, 2005; 33 SDR 59, effective October 5, 2006; 34 SDR 271, effective May 6, 2008; 35 SDR 183, effective February 2, 2009.

**General Authority:** SDCL 58-17A-2.

**Law Implemented:** SDCL 58-17A-2.

**Reference:** **Current Procedural Coding Expert, 2008,** American Medical Association. Copies may be obtained from Medicode, 5225 Wiley Post Way, Suite 500, Salt Lake City, UT 84116-2889; 1-800-999-4600; <www.ingenixonline.com>. Cost: $97.95.