THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT (EXCERPT)
Act 350 of 1980

550.1459 Benefits in addition to basic core package; conformance to § 550.1461(5)(b) to (j); reimbursement for preventative screening tests and services; definitions.

Sec. 459. (1) In addition to the basic core package of benefits required under section 455, the following benefits may be included in a medicare supplement certificate and if included shall conform to section 461(5)(b) to (j):

(a) Medicare part A deductible: coverage for all of the medicare part A inpatient hospital deductible amount per benefit period.

(b) 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.

(c) Medicare part B deductible: coverage for all of the medicare part B deductible amount per calendar year regardless of hospital confinement.

(d) 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 medicare or state law, and the medicare-approved part B charge.

(e) 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 medicare or state law, and the medicare-approved part B charge.

(f) Basic outpatient prescription drug benefit: coverage for 50% of outpatient prescription drug charges, after a $250.00 calendar year deductible, to a maximum of $1,250.00 in benefits received by the member per calendar year, to the extent not covered by medicare.

(g) Extended outpatient prescription drug benefit: coverage for 50% of outpatient prescription drug charges, after a $250.00 calendar year deductible, to a maximum of $3,000.00 in benefits received by the member per calendar year, to the extent not covered by medicare.

(h) 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 $250.00, and a lifetime maximum benefit of $50,000.00. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

(i) Preventive medical care benefit: coverage for the following preventive health services:

(*i*) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (*ii*) and patient education to address preventive health care measures.

(*ii*) Any 1 or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(A) Digital rectal examination.

(B) Dipstick urinalysis for hematuria, bacteriuria, and proteinuria.

(C) Pure tone, air only, hearing screening test, administered or ordered by a physician.

(D) Serum cholesterol screening every 5 years.

(E) Thyroid function test.

(F) Diabetes screening.

(G) Tetanus and diphtheria booster every 10 years.

(H) Any other tests or preventive measures determined appropriate by the attending physician.

(j) 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. At-home recovery services provided shall be primarily services that assist in activities of daily living. The member's attending physician shall 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. Coverage is excluded for home care visits paid for by medicare or other government programs and care provided by family members, unpaid volunteers, or providers who are not care providers. Coverage is limited to:

(*i*) No more than the number of at-home recovery visits certified as necessary by the member'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.

(*ii*) The actual charges for each visit up to a maximum reimbursement of $40.00 per visit.

(*iii*) One thousand six hundred dollars per calendar year.

(*iv*) Seven visits in any 1 week.

(*v*) Care furnished on a visiting basis in the member's home.

(*vi*) Services provided by a care provider as defined in this section.

(*vii*) At-home recovery visits while the member is covered under the certificate and not otherwise excluded.

(*viii*) At-home recovery visits received during the period the member 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.

(k) New or innovative benefits: a health care corporation may, with the prior approval of the commissioner, offer new or innovative benefits in addition to the benefits provided in a certificate that otherwise complies with the applicable standards. These benefits may include benefits that are appropriate to medicare supplement coverage, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of medicare supplement certificates.

(2) Reimbursement for the preventive screening tests and services under subsection (1)(i)(*ii*) shall be for the actual charges up to 100% of the medicare-approved amount for each test or service, as if medicare were to cover the test or service as identified in the American medical association current procedural terminology codes, to a maximum of $120.00 annually under this benefit. This benefit shall not include payment for any procedure covered by medicare.

(3) As used in subsection (1)(j):

(a) “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.

(b) “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.

(c) “Home” means any place used by the member as a place of residence, provided that it qualifies as a residence for home health care services covered by medicare. A hospital or skilled nursing facility shall not be considered the member's home.

(d) “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 1 visit.

History: Add. 1994, Act 40, Imd. Eff. Mar. 14, 1994;—Am. 2002, Act 559, Imd. Eff. Sept. 27, 2002.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350