THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

CHAPTER 38

MEDICARE SUPPLEMENT POLICIES AND CERTIFICATES

500.3801 Chapter; definitions.

Sec. 3801. As used in this chapter:

(a) "Applicant" means:

(*i*) For an individual Medicare supplement policy, the person who seeks to contract for benefits.

(*ii*) For a group Medicare supplement policy or certificate, the proposed certificate holder.

(b) "Bankruptcy" means, with respect to a Medicare advantage organization that is not an insurer, that the organization has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in this state.

(c) "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

(d) "Certificate form" means the form on which a certificate is delivered or issued for delivery by an insurer.

(e) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

(f) "Creditable coverage" means coverage of an individual provided under any of the following:

(*i*) A group health plan.

(*ii*) Health insurance coverage.

(*iii*) Part A or part B of Medicare.

(*iv*) Medicaid other than coverage consisting solely of benefits under 42 USC 1396s.

(*v*) Chapter 55 of title 10 of the United States Code, 10 USC 1071 to 1110b.

(*vi*) A medical care program of the Indian Health Service or of a tribal organization.

(*vii*) A state health benefits risk pool.

(*viii*) A health plan offered under chapter 89 of title 5 of the United States Code, 5 USC 8901 to 8914.

(*ix*) A public health plan as defined in federal regulation.

(*x*) Health care under 22 USC 2504(e).

(g) "Direct response solicitation" means solicitation in which an insurer representative does not contact the applicant in person and explain the coverage available, such as, but not limited to, solicitation through direct mail or through advertisements in periodicals and other media.

(h) "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in 29 USC 1002.

(i) "Insolvency" means, with respect to an insurer licensed to transact the business of insurance in this state, that the insurer has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the insurer's state of domicile.

(j) "Insurer" includes any person that delivers or issues for delivery in this state Medicare supplement policies.

(k) "Medicaid" means subchapter XIX of the social security act, 42 USC 1396 to 1396w-5.

(*l*) "Medicare" means subchapter XVIII of the social security act, 42 USC 1395 to 1395*lll.*

(m) "Medicare advantage" means a plan of coverage for health benefits under Medicare part C as described in 42 USC 1395w-28, and includes any of the following:

(*i*) Coordinated care plans that provide health care services, including, but not limited to, health maintenance organization plans with or without a point-of-service option, plans offered by provider-sponsored organizations, and preferred provider organization plans.

(*ii*) Medical savings account plans coupled with a contribution into a Medicare advantage medical savings account.

(*iii*) Medicare advantage private fee-for-service plans.

(n) "Medicare supplement buyer's guide" means the document entitled, "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare", developed by the National Association of Insurance Commissioners and the United States Department of Health and Human Services, or a substantially similar document as approved by the director.

(o) "Medicare supplement policy" means an individual or group policy or certificate that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical,

or surgical expenses of persons eligible for Medicare and Medicare select policies and certificates under section 3817. Medicare supplement policy does not include a policy, certificate, or contract of 1 or more employers or labor organizations, or of the trustees of a fund established by 1 or more employers or labor organizations, or both, for employees or former employees, or both, or for members or former members, or both, of the labor organizations. Medicare supplement policy does not include Medicare advantage plans established under Medicare part C, outpatient prescription drug plans established under Medicare part D, or any health care prepayment plan that provides benefits pursuant to an agreement under 42 USC 1395*l*(a)(1).

(p) "PACE" means a program of all-inclusive care for the elderly as described in the social security act.

(q) "Prestandardized Medicare supplement benefit plan", "prestandardized benefit plan", or "prestandardized plan" means a group or individual policy of Medicare supplement insurance issued before June 2, 1992.

(r) "1990 standardized Medicare supplement benefit plan", "1990 standardized benefit plan", or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after June 2, 1992 with an effective date for coverage before June 1, 2010 and includes Medicare supplement insurance policies and certificates renewed on or after that date that are not replaced by the issuer at the request of the insured.

(s) "2010 standardized Medicare supplement benefit plan", "2010 standardized benefit plan", or "2010 plan" means a group or individual policy of Medicare supplement insurance with an effective date for coverage on or after June 1, 2010.

(t) "Policy form" means the form on which the policy or certificate is delivered or issued for delivery by the insurer.

(u) "Secretary" means the secretary of the United States Department of Health and Human Services.

(v) "Social security act" means the social security act, 42 USC 301 to 1397mm.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006;—Am. 2009, Act 220, Imd. Eff. Jan. 5, 2010;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3803 Applicability of chapter.

Sec. 3803. (1) Except as provided in subsections (2) and (3), this chapter applies to a Medicare supplement policy delivered, issued for delivery, or renewed in this state.

(2) Sections 3807, 3809, 3811, and 3819 apply to a Medicare supplement policy delivered or issued for delivery in this state on or after June 2, 1992 with an effective date for coverage before June 1, 2010.

(3) Sections 3807a, 3809a, 3811a, and 3819a apply to a Medicare supplement policy delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2009, Act 220, Imd. Eff. Jan. 5, 2010;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3804 Repealed. 2018, Act 429, Eff. Mar. 20, 2019.

Compiler's note: The repealed section pertained to the applicability of medicare supplement policies by a certain health care corporation.

Popular name: Act 218

500.3805 Medicare supplement policy; definitions.

Sec. 3805. As used in a medicare supplement policy:

(a) The definition of "accident", "accidental injury", or "accidental means" shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization. The definition may provide that injuries shall not include injuries for which benefits are provided or available under any worker's compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

(b) The definition of "benefit period" or "medicare benefit period" shall not be defined in a more restrictive manner than as defined in medicare.

(c) "Hospital" may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the joint commission on accreditation of hospitals, but not more restrictively than as defined in medicare.

(d) The definition of "medicare eligible expenses" shall mean health care expenses of the kinds covered by part A and part B of medicare, to the extent recognized as reasonable and medically necessary by medicare.

(e) "Nurses" may be defined so that the description of nurse is to a type of nurse, such as a registered professional nurse or a licensed practical nurse. If the words "nurse", "trained nurse", or "registered nurse" are

used without specific instruction, then the use of those terms requires the insurer to recognize the services of any individual who qualifies under those terms in accordance with the public health code, 1978 PA 368, MCL 333.1101 to 333.25211.

(f) "Physician" shall not be defined more restrictively than as defined in medicare.

(g) "Sickness" shall not be defined more restrictively than to mean illness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. The definition may be further modified to exclude sicknesses or diseases for which benefits are provided to the insured under any worker's compensation, occupational disease, employer's liability, or similar law.

(h) "Skilled nursing facility" shall not be defined more restrictively than as defined in medicare.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006.

Popular name: Act 218

500.3807 Basic core package of benefits; standards for plans K and L; applicability of section.

Sec. 3807. (1) Every insurer issuing a medicare supplement insurance policy in this state shall make available a medicare supplement insurance policy that includes a basic core package of benefits to each prospective insured. An insurer issuing a medicare supplement insurance policy in this state may make available to prospective insureds benefits pursuant to section 3809 that are in addition to, but not instead of, the basic core package. The basic core package of benefits shall include all of the following:

(a) Coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the sixty-first day through the ninetieth day in any medicare benefit period.

(b) 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.

(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 rate or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the insurer's payment as payment in full and may not bill the insured for any balance.

(d) 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.

(e) Coverage for the coinsurance amount, or the copayment amount paid for hospital outpatient department services under a prospective payment system, of medicare eligible expenses under part B regardless of hospital confinement, subject to the medicare part B deductible.

(2) Standards for plans K and L are as follows:

(a) Standardized medicare supplement benefit plan K shall consist of the following:

(*i*) Coverage of 100% of the part A hospital coinsurance amount for each day used from the sixty-first day through the ninetieth day in any medicare benefit period.

(*ii*) Coverage of 100% of the part A hospital coinsurance amount for each medicare lifetime inpatient reserve day used from the ninety-first day through the one hundred fiftieth day in any medicare benefit period.

(*iii*) 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 rate, or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the insurer's payment as payment in full and may not bill the insured for any balance.

(*iv*) 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 subparagraph (*x*).

(*v*) Skilled nursing facility care: coverage for 50% of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare part A until the out-of-pocket limitation is met as described in subparagraph (*x*).

(*vi*) 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 subparagraph (*x*).

(*vii*) 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 subparagraph (*x*).

(*viii*) Except for coverage provided in subparagraph (*ix*) below, 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 subparagraph (*x*).

(*ix*) Coverage of 100% of the cost sharing for medicare part B preventive services after the policyholder pays the part B deductible.

(*x*) 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 $4,000.00 in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary of the United States department of health and human services.

(b) Standardized medicare supplement benefit plan L shall consist of the following:

(*i*) The benefits described in subdivision (a)(*i*), (*ii*), (*iii*), and (*ix*).

(*ii*) The benefit described in subdivision (a)(*iv*), (*v*), (*vi*), (*vii*), and (*viii*), but substituting 75% for 50%.

(*iii*) The benefit described in subdivision (a)(*x*), but substituting $2,000.00 for $4,000.00.

(3) This section applies to medicare supplement policies or certificates delivered or issued for delivery with an effective date for coverage prior to June 1, 2010.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006;—Am. 2009, Act 220, Imd. Eff. Jan. 5, 2010.

Popular name: Act 218

500.3807a Medicare supplement policies or certificates with effective date for coverage on or after June 1, 2010; basic core package of benefits.

Sec. 3807a. (1) This section applies to all medicare supplement policies or certificates delivered or issued for delivery with an effective date for coverage on or after June 1, 2010. A policy or certificate shall not 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. An issuer shall not offer any 1990 plan for sale on or after June 1, 2010. Benefit standards applicable to medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of section 3807.

(2) Every insurer issuing a medicare supplement insurance policy in this state shall make available a medicare supplement insurance policy that includes a basic core package of benefits to each prospective insured. An insurer issuing a medicare supplement insurance policy in this state may make available to prospective insureds benefits pursuant to section 3809a that are in addition to, but not instead of, the basic core package. The basic core package of benefits shall include all of the following:

(a) Coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the sixty-first day through the ninetieth day in any medicare benefit period.

(b) 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.

(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 rate or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the insurer's payment as payment in full and may not bill the insured for any balance.

(d) 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.

(e) Coverage for the coinsurance amount, or the copayment amount paid for hospital outpatient department services under a prospective payment system, of medicare eligible expenses under part B regardless of hospital confinement, subject to the medicare part B deductible.

(f) Coverage of cost sharing for all part A medicare eligible hospice care and respite care expenses.

History: Add. 2009, Act 220, Imd. Eff. Jan. 5, 2010.

Popular name: Act 218

500.3808 Repealed. 2018, Act 429, Eff. Mar. 20, 2019.

Compiler's note: The repealed section pertained to medicare supplement insurance policies.

Popular name: Act 218

500.3809 Additional benefits; reimbursement for preventive screening tests and services; definitions; applicability of section.

Sec. 3809. (1) In addition to the basic core package of benefits required under section 3807, the following benefits may be included in a medicare supplement insurance policy and if included shall conform to section 3811(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 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.

(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 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.

(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 not covered by medicare:

(*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*) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically 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 insured'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 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.

(*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 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 insurance policy and not otherwise excluded.

(*viii*) 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.

(k) New or innovative benefits: an insurer may, with the prior approval of the commissioner, 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. The new or innovative benefits may include benefits that are appropriate to medicare supplement insurance, new or innovative, not otherwise available,

cost-effective, and offered in a manner that is consistent with the goal of simplification of medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

(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 insured 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 insured'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.

(4) This section applies to medicare supplement policies or certificates delivered or issued for delivery on or after June 2, 1992 with an effective date for coverage prior to June 1, 2010.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006;—Am. 2009, Act 220, Imd. Eff. Jan. 5, 2010.

Popular name: Act 218

500.3809a Medicare supplement policies or certificates with effective date for coverage on or after June 1, 2010; additional benefits.

Sec. 3809a. (1) This section applies to all medicare supplement policies or certificates delivered or issued for delivery with an effective date for coverage on or after June 1, 2010.

(2) In addition to the basic core package of benefits required under section 3807a, the following benefits may be included in a medicare supplement insurance policy and if included shall conform to section 3811a(6)(b) to (j):

(a) Medicare part A deductible: coverage for 100% of the medicare part A inpatient hospital deductible amount per benefit period.

(b) Medicare part A deductible: coverage for 50% of the medicare part A inpatient hospital deductible amount per benefit period.

(c) Skilled nursing facility care: coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare part A.

(d) Medicare part B deductible: coverage for 100% of the medicare part B deductible amount per calendar year regardless of hospital confinement.

(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) 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.

History: Add. 2009, Act 220, Imd. Eff. Jan. 5, 2010.

Popular name: Act 218

500.3811 Basic core benefits; availability; sale of certain benefits prohibited; designations, structure, language, and format; other designations; requirements; applicability of section.

Sec. 3811. (1) An insurer shall make available to each prospective medicare supplement policyholder and certificate holder a policy form or certificate form containing only the basic core benefits as provided in section 3807.

(2) Groups, packages, or combinations of medicare supplement benefits other than those listed in this section shall not be offered for sale in this state except as may be permitted in section 3809(1)(k).

(3) Benefit plans shall contain the appropriate A through L designations, shall be uniform in structure, language, and format to the standard benefit plans in subsection (5), and shall conform to the definitions in this chapter. Each benefit shall be structured in accordance with sections 3807 and 3809 and list the benefits in the order shown in subsection (5). For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

(4) In addition to the benefit plan designations A through L as provided under subsection (5), an insurer may use other designations to the extent permitted by law.

(5) A medicare supplement insurance benefit plan shall conform to 1 of the following:

(a) A standardized medicare supplement benefit plan A shall be limited to the basic core benefits common to all benefit plans as defined in section 3807.

(b) A standardized medicare supplement benefit plan B shall include only the following: the core benefits as defined in section 3807 and the medicare part A deductible as defined in section 3809(1)(a).

(c) A standardized medicare supplement benefit plan C shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, medicare part B deductible, and medically necessary emergency care in a foreign country as defined in section 3809(1)(a), (b), (c), and (h).

(d) A standardized medicare supplement benefit plan D shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in section 3809(1)(a), (b), (h), and (j).

(e) A standardized medicare supplement benefit plan E shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and preventive medical care as defined in section 3809(1)(a), (b), (h), and (i).

(f) A standardized medicare supplement benefit plan F shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, medicare part B deductible, 100% of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 3809(1)(a), (b), (c), (e), and (h). A standardized medicare supplement plan F high deductible shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan F deductible. The covered expenses include the core benefits as defined in section 3807, plus the medicare part A deductible, skilled nursing facility care, the medicare part B deductible, 100% of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 3809(1)(a), (b), (c), (e), and (h). The annual high deductible plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan F policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible plan F deductible is $1,790.00 for calendar year 2006, and the secretary shall adjust it annually thereafter to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, rounded to the nearest multiple of $10.00.

(g) A standardized medicare supplement benefit plan G shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, 80% of the medicare part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in section 3809(1)(a), (b), (d), (h), and (j).

(h) A standardized medicare supplement benefit plan H shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, basic outpatient prescription drug benefit, and medically necessary emergency care in a foreign country as defined in section 3809(1)(a), (b), (f), and (h). The outpatient drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

(i) A standardized medicare supplement benefit plan I shall include only the following: the core benefits as defined in section 3807, the medicare part A deductible, skilled nursing facility care, 100% of the medicare part B excess charges, basic outpatient prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in section 3809(1)(a), (b), (e), (f), (h), and (j). The outpatient drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

(j) A standardized medicare supplement benefit plan J shall include only the following: the core benefits as

defined in section 3807, the medicare part A deductible, skilled nursing facility care, medicare part B deductible, 100% of the medicare part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in section 3809(1)(a), (b), (c), (e), (g), (h), (i), and (j). A standardized medicare supplement benefit plan J high deductible plan shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan J deductible. The covered expenses include the core benefits as defined in section 3807, plus the medicare part A deductible, skilled nursing facility care, medicare part B deductible, 100% of the medicare part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in section 3809(1)(a), (b), (c), (e), (g), (h), (i), and (j). The annual high deductible plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan J policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1,790.00 for calendar year 2006, and the secretary shall adjust it annually thereafter to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, rounded to the nearest multiple of $10.00. The outpatient drug benefit shall not be included in a medicare supplement policy sold after December 31, 2005.

(k) A standardized medicare supplement benefit plan K shall consist of only those benefits described in section 3807(2)(a).

(*l*) A standardized medicare supplement benefit plan L shall consist of only those benefits described in section 3807(2)(b).

(6) This section applies to medicare supplement policies or certificates delivered or issued for delivery on or after June 2, 1992 with an effective date for coverage prior to June 1, 2010.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006;—Am. 2009, Act 220, Imd. Eff. Jan. 5, 2010.

Popular name: Act 218

500.3811a Medicare supplement policies or certificates with effective date for coverage on or after June 1, 2010; basic core benefits; availability; sale of certain benefits prohibited; structure, language, designation, and format; other designations; requirements.

Sec. 3811a. (1) This section applies to all Medicare supplement policies or certificates delivered or issued for delivery with an effective date for coverage on or after June 1, 2010. A policy or certificate must not 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. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of section 3811.

(2) An insurer shall make available to each prospective Medicare supplement policyholder and certificate holder a policy form or certificate form containing only the basic core benefits as provided in section 3807a. If an insurer makes available any of the additional benefits described in section 3809a or offers standardized benefit plans K or L, the insurer shall make available to each prospective Medicare supplement policyholder and certificate holder a policy form or certificate form containing either standardized benefit plan C or standardized benefit plan F.

(3) Groups, packages, or combinations of Medicare supplement benefits other than those listed in this section must not be offered for sale in this state except as may be permitted in subsection (6)(k).

(4) Benefit plans must be uniform in structure, language, designation, and format to the standard benefit plans in subsection (6) and must conform to the definitions in this chapter. Each benefit must be structured in accordance with sections 3807a and 3809a and list the benefits in the order shown in subsection (6). As used in this section, "structure, language, designation, and format" means style, arrangement, and overall content of a benefit.

(5) In addition to the benefit plan designations as provided under subsection (6), an insurer may use other designations to the extent permitted by law.

(6) A Medicare supplement insurance benefit plan must conform to 1 of the following:

(a) A standardized Medicare supplement benefit plan A must be limited to the basic core benefits common to all benefit plans as required under section 3807a.

(b) A standardized Medicare supplement benefit plan B must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible as defined in section 3809a(2)(a).

(c) A standardized Medicare supplement benefit plan C must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care,

100% of the Medicare part B deductible, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), (d), and (f).

(d) A standardized Medicare supplement benefit plan D must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), and (f).

(e) A standardized Medicare supplement benefit plan F must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care, 100% of the Medicare part B deductible, 100% of the Medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), (d), (e), and (f). A standardized Medicare supplement plan F high deductible must include only the following: 100% of covered expenses following the payment of the annual high-deductible plan F deductible. The covered expenses include the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care, 100% of the Medicare part B deductible, 100% of the Medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), (d), (e), and (f). The annual high-deductible plan F deductible must consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan F policy, and must be in addition to any other specific benefit deductibles. The annual high-deductible plan F deductible is $1,500.00 for calendar year 1999, and the secretary shall adjust it annually thereafter to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, rounded to the nearest multiple of $10.00.

(f) A standardized Medicare supplement benefit plan G must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care, 100% of the Medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), (e), and (f). Effective January 1, 2020, the standardized plan F high deductible benefit plan, redesignated in section 3811b(2)(d) as plan G high deductible, may be offered to an individual who was eligible for Medicare before January 1, 2020.

(g) Standardized Medicare supplement benefit plan K must consist of the following:

(*i*) Coverage of 100% of the part A hospital coinsurance amount for each day used from the sixty-first day through the ninetieth day in any Medicare benefit period.

(*ii*) Coverage of 100% of the part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first day through the one hundred fiftieth day in any Medicare benefit period.

(*iii*) On 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 rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the insurer's payment as payment in full and may not bill the insured for any balance.

(*iv*) 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 subparagraph (*x*).

(*v*) Skilled nursing facility care: coverage for 50% of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare part A until the out-of-pocket limitation is met as described in subparagraph (*x*).

(*vi*) 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 subparagraph (*x*).

(*vii*) 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 subparagraph (*x*).

(*viii*) Except for coverage provided in subparagraph (*ix*), 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 subparagraph (*x*).

(*ix*) Coverage of 100% of the cost sharing for Medicare part B preventive services after the policyholder pays the part B deductible.

(*x*) 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 $4,000.00 in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary of the United States Department of Health and Human Services.

(h) Standardized Medicare supplement benefit plan L must consist of the following:

(*i*) The benefits described in subdivision (g)(*i*), (*ii*), (*iii*), and (*ix*).

(*ii*) The benefits described in subdivision (g)(*iv*), (*v*), (*vi*), (*vii*), and (*viii*), but substituting 75% for 50%.

(*iii*) The benefit described in subdivision (g)(*x*), but substituting $2,000.00 for $4,000.00.

(i) A standardized Medicare supplement benefit plan M must include only the following: the core benefits as required under section 3807a and 50% of the Medicare part A deductible, skilled nursing care, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(b), (c), and (f).

(j) A standardized Medicare supplement benefit plan N must include only the following: the core benefits as required under section 3807a and 100% of the Medicare part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in section 3809a(2)(a), (c), and (f) with copayments in the following amounts:

(*i*) The lesser of $20.00 or the Medicare part B coinsurance or copayment for each covered health care provider office visit, including visits to medical specialists.

(*ii*) The lesser of $50.00 or the Medicare part B coinsurance or copayment for each covered emergency room visit. The copayment must be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare part A expense.

(k) New or innovative benefits: an insurer 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. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies. The innovative benefit must not include an outpatient prescription drug benefit. New or innovative benefits must not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

History: Add. 2009, Act 220, Imd. Eff. Jan. 5, 2010;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3811b Medicare supplement policies or certificates for newly eligible individuals after December 31, 2019; exceptions to standards and requirements.

Sec. 3811b. (1) This section applies to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare after December 31, 2019. A policy or certificate that provides coverage of the Medicare part B deductible must not be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare after December 31, 2019, unless it complies with the benefit standards provided in this section. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020 remain subject to the requirements of section 3811a.

(2) The standards and requirements of section 3811a apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare after December 31, 2019, with the following exceptions:

(a) Standardized Medicare supplement benefit plan C is redesignated as plan D and must provide the benefits contained in section 3811a(6)(c), but must not provide coverage for 100% or any portion of the Medicare part B deductible.

(b) Standardized Medicare supplement benefit plan F is redesignated as plan G and must provide the benefits contained in section 3811a(6)(e), as applicable, but must not provide coverage for 100% or any portion of the Medicare part B deductible.

(c) Standardized Medicare supplement benefit plans C, F, and F high deductible may not be offered to individuals newly eligible for Medicare after December 31, 2019.

(d) Standardized Medicare supplement benefit plan F high deductible is redesignated as plan G high deductible and must provide the benefits in section 3811a(6)(e), as applicable, but must not provide coverage for 100% or any portion of the Medicare part B deductible. The Medicare part B deductible paid by the beneficiary is considered an out-of-pocket expense in meeting the annual high deductible.

(e) The reference to plan C or plan F contained in section 3811a(2) is deemed a reference to plan D or plan G, respectively, for purposes of this section.

(3) This section only applies to individuals that are newly eligible for Medicare after December 31, 2019 because of either of the following:

(a) By reason of attaining age 65 after December 31, 2019.

(b) By reason of entitlement to benefits under Medicare part A under section 226(b) or 226a of the social security act, or who is deemed to be eligible for benefits under section 226a of the social security act after December 31, 2019.

(4) For purposes of section 3830(5) to (8), for an individual newly eligible for Medicare after December 31, 2019, any reference to Medicare supplement policy or certificate plans C, F, or F high deductible is deemed to be a reference to Medicare supplement policy or certificate plans D, G, or G high deductible, respectively, that meet the requirements of subsection (2).

(5) After December 31, 2019, the standardized benefit plans described in subsection (2)(d) may be offered to an individual who was eligible for Medicare before January 1, 2020, in addition to the standardized plans described in section 3811a(6).

History: Add. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3813 Disability coverage; medicare supplement buyer's guide; applicability of section.

Sec. 3813. An insurer that issues a policy that provides health insurance coverage to a person eligible for Medicare by reason of age shall provide the prospective policyholder with a Medicare supplement buyer's guide in written or electronic format, which must be furnished at the time of application, and the insurer shall obtain, in written or electronic format, acknowledgment of receipt of the buyer's guide. However, for direct response solicitation policies, the guide must be furnished with the policy in written or electronic format and the insurer need not obtain acknowledgment of receipt. This section does not apply to policies that provide accidental death benefits for travel or other accidents, or if the medical expense or indemnity payments are only incidental to the accidental death benefits for travel or other accidents.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3815 Outline of coverage; acknowledgment of receipt; compliance with notice requirements; substitute; language, written or electronic format, and required items.

Sec. 3815. (1) An insurer that offers a Medicare supplement policy shall provide to the applicant at the time of application an outline of coverage in written or electronic format and, except for direct response solicitation policies, shall obtain an acknowledgment of receipt of the outline of coverage from the applicant in written or electronic format. The outline of coverage provided to applicants under this section must consist of the following 4 parts:

(a) A cover page.

(b) Premium information.

(c) Disclosure pages.

(d) Charts displaying the features of each benefit plan offered by the insurer.

(2) Insurers shall comply with any notice requirements of the Medicare prescription drug, improvement, and modernization act of 2003, Public Law 108-173.

(3) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and must contain the following statement, in not less than 12-point type, immediately above the company name:

```
NOTICE: Read this outline of coverage carefully.
It is not identical to the outline of coverage
provided on application and the coverage
originally applied for has not been issued.
```

(4) An outline of coverage under subsection (1) must be in the language and in a written or electronic format prescribed in this section and in not less than 12-point type. The letter designation of the plan must be shown on the cover page and the plans offered by the insurer must be prominently identified. Premium information must be shown on the cover page or immediately following the cover page and must be prominently displayed. The premium and method of payment mode must be stated for all plans that are offered to the applicant. All possible premiums for the applicant must be illustrated. The following items must be included in the outline of coverage in the order prescribed below and in substantially the following form, as approved by the director:

```
BENEFIT CHART OF MEDICARE SUPPLEMENT PLANS SOLD
          ON OR AFTER JUNE 1, 2010
```

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Plans E, H, I, and J are no longer available for sale. (This sentence must not appear after June 1, 2011.)

BASIC BENEFITS:

Hospitalization: Part A coinsurance plus coverage for 365

additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.
Blood: First three pints of blood each year.
Hospice: Part A coinsurance

A	B	C**	D	F|F* **	G/G*
Basic, including 100% Part B coin-surance	Basic, including 100% Part B coinsur-ance	Basic, including 100% Part B coinsur-ance	Basic, including 100% Part B coinsur-ance	Basic, including 100% Part B coinsur-ance	Basic, including 100% Part B coinsur-ance
		Skilled Nursing Facility Coinsur-ance	Skilled Nursing Facility Coinsur-ance	Skilled Nursing Facility Coinsur-ance	Skilled Nursing Facility Coinsur-ance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible	
				Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, includ-ing 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copay-ment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $5,240; paid at 100% after limit reached	Out-of-pocket limit $2,620; paid at 100% after limit reached		

* Plans F and G also have options called high-deductible Plan F and high-deductible Plan G. These high-deductible plans pay the same benefits as Plan F or Plan G, as applicable, after one has paid a calendar year $2,240 deductible. Benefits from high-deductible Plan F or high-deductible Plan G will not begin until

out-of-pocket expenses exceed $2,240. Out-of-pocket expenses for these deductibles are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

** Plan C, Plan F, and high-deductible Plan F are only available to individuals eligible for Medicare before January 1, 2020.

PREMIUM INFORMATION

We (insert insurer's name) can only raise your premium if we raise the premium for all policies like yours in this state. (If the premium is based on the increasing age of the insured, include information specifying when premiums will change).

DISCLOSURES

Use this outline to compare benefits and premiums among policies, certificates, and contracts.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates before June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. (This sentence must not appear after June 1, 2011.)

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to (insert insurer's address). If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do not cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

[For agent issued policies]

Neither (insert insurer's name) nor its agents are connected with Medicare.

[For direct response issued policies]

(Insert insurer's name) is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local social security office or consult "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan offered by the insurer a chart showing the services, Medicare payments, plan payments, and insured payments using the same language, in the same order, and using uniform layout and format as shown in the charts that follow. An insurer may use additional benefit plan designations on these charts under section 3809(1)(k). Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the director. The insurer issuing the policy shall change the dollar amounts each year to reflect current figures. No more than 4 plans may be shown on 1 chart.] Charts for each plan are as follows:

PLAN A

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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but	$0	$1,340

	$1,340		(Part A Deductible)
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	$0	Up to $167.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**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 A

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $183 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
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 $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD First 3 pints	$0	All Costs	$0
Next $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Tests for diagnostic services	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
PLAN B			

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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $1,340	$1,340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after —While using 60 lifetime reserve days	All but	$670	$0

—Once lifetime reserve days are used:	$670 a day	a day	
—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 $167.50 a day	$0	Up to $167.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**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 B

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $183 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
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 $183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	$0 80% $0	$0 20% $0	$183 (Part B Deductible) $0 All Costs
BLOOD First 3 pints Next $183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 $0 80%	All Costs $0 20%	$0 $183 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES— Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies —Durable medical equipment First $183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $183 (Part B Deductible) $0

PLAN C

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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after —While using 60	All but $1,340 All but $335 a day	$1,340 (Part A Deductible) $335 a day	$0 $0

lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	Up to $167.50 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**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 C

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $183 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
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 $183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	 $0 80% $0	 $183 (Part B Deductible) 20% $0	 $0 $0 All Costs
BLOOD First 3 pints Next $183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All Costs $183 (Part B Deductible) 20%	 $0 $0 $0
CLINICAL LABORATORY SERVICES— Tests for diagnostic services	 100%	 $0	 $0
PARTS A & B			
HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies —Durable medical equipment First $183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $183 (Part B Deductible) 20%	 $0 $0 $0
OTHER BENEFITS—NOT COVERED BY MEDICARE			
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

PLAN D

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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$1,340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after —While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	Up to $167.50 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 You must meet	All but very limited copayment/ coinsurance for outpatient	Medicare copayment/ coinsurance	$0

Medicare's requirements, including a doctor's certification of terminal illness	drugs and inpatient respite care		

**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 D

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $183 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
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 $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Tests for diagnostic services	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE Medicare Approved Services			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)

Remainder of Medicare Approved Amounts	80%	20%	$0
OTHER BENEFITS—NOT COVERED BY MEDICARE			
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

PLAN F OR HIGH-DEDUCTIBLE PLAN F

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.

**This high-deductible plan pays the same benefits as plan F after you have paid a calendar year $2,240 deductible. Benefits from the high-deductible plan F will not begin until out-of-pocket expenses are $2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes 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 $2,240 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $2,240 DEDUCTIBLE**, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $1,340	$1,340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after —While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	Up to $167.50 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

***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 F

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $183 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 F after you have paid a calendar year $2,240 deductible. Benefits from the high-deductible plan F will not begin until out-of-pocket expenses are $2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes 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 $2,240 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $2,240 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 $183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	$0 80% $0	$183 (Part B Deductible) 20% 100%	$0 $0 $0
BLOOD First 3 pints Next $183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 $0 80%	All Costs $183 (Part B Deductible) 20%	$0 $0 $0
CLINICAL LABORATORY SERVICES— Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies —Durable medical equipment First $183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $183 (Part B Deductible) 20%	$0 $0 $0

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN G OR HIGH-DEDUCTIBLE PLAN G

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.

** This high-deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,240 deductible. Benefits from the high-deductible Plan G will not begin until out-of-pocket expenses are $2,240. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,240 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $2,240 DEDUCTIBLE**, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$1,340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	Up to $167.50 a day	$0
101st day and after	$0	$0	All costs

BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

***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 G OR HIGH-DEDUCTIBLE PLAN G

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $183 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 G after one has paid a calendar year $2,240 deductible. Benefits from the high-deductible Plan G will not begin until out-of-pocket expenses are $2,240. Out-of-pocket expenses for this deductible include expenses for the Medicare part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,240 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $2,240 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 $183 of Medicare Approved Amounts*	$0	$0	$163 (Unless Part B Deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0

Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	0%
BLOOD			
First 3 pints	$0	All Costs	$0
Next $183 of Medicare Approved Amounts*	$0	$0	$183 (Unless Part B Deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE Medicare Approved Services			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

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	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $5,240 each calendar year. The amounts that count toward your annual limit are noted with diamonds[1] 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.

PLAN K

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*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$670 (50% of Part A Deducti-ble)	$670 (50% of Part A Deductible) 1
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	Up to $83.75 a day	Up to $83.75 a day 1
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50% 1
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for	50% of copayment/ coinsur-ance	50% of Medicare copayment/ coinsurance 1

	outpatient drugs and inpatient respite care		

***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 K

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

****Once you have been billed $183 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*
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 $183 of Medicare Approved Amounts****	$0	$0	$183 (Part B Deductible) **** 1
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% 1
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $5,240)*
BLOOD			
First 3 pints	$0	50%	50% 1
Next $183 of Medicare Approved Amounts****	$0	$0	$183 (Part B Deductible) **** 1
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% 1
CLINICAL LABORATORY SERVICES—Tests for diagnostic services	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $5,240 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.

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $183 of Medicare Approved Amounts*****	$0	$0	$183 (Part B Deductible)1
Remainder of Medicare Approved Amounts	80%	10%	10% 1

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

PLAN L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2,620 each calendar year. The amounts that count toward your annual limit are noted with diamonds[1] 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.

PLAN L

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*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$1,005 (75% of Part A Deducti-ble)	$335 (25% of Part A Deductible) 1
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after: —While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	Up to $125.63 a day	Up to $41.88 a day 1
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25% 1
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	75% of copayment/coinsurance	25% of copayment/coinsurance 1

***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 $183 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*
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 $183 of Medicare Approved Amounts****	$0	$0	$183 (Part B Deductible)**** 1
Preventive Benefits for	Generally 75%	Remainder	All costs

Medicare covered services Remainder of Medicare Approved Amounts	or more of Medicare approved amounts Generally 80%	of Medicare approved amounts Generally 15%	above Medicare approved amounts Generally 5% 1
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $2,620)*
BLOOD First 3 pints Next $183 of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	$0 $0 Generally 80%	75% $0 Generally 15%	25% 1 $183 (Part B Deductible) 1 Generally 5% 1
CLINICAL LABORATORY SERVICES—Tests for diagnostic services	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $2,620 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.

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies —Durable medical equipment First $183 of Medicare Approved Amounts***** Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 15%	$0 $183 (Part B Deductible) 1 5% 1

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

PLAN M

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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but $1,340	$670 (50% of Part A	$670 (50% of Part A

		Deduc-tible)	Deduc-tible)
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	Up to $167.50 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**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 M

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $183 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

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 $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deduc-tible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deduc-tible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—Tests for diagnostic services	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE Medicare Approved Services			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $183 of Medicare Approved Amounts	$0	$0	$183 (Part B Deduc-tible)
Remainder of Medicare Approved Amounts	80%	20%	$0
OTHER BENEFITS—NOT COVERED BY MEDICARE			
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	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

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*
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,340	$1,340 (Part A Deduc-tible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	Up to $167.50 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**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 N

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $183 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
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 $183 of Medicare Approved Amounts*	$0	$0	$183 (Part B Deduc-tible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as

		covered as a Medicare Part A expense.	a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 $0 80%	All Costs $0 20%	$0 $183 (Part B Deduc-tible) $0
CLINICAL LABORATORY SERVICES—Tests for diagnostic services	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies —Durable medical equipment First $183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $183 (Part B Deduc-tible) $0
OTHER BENEFITS—NOT COVERED BY MEDICARE			
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

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006;—Am. 2009, Act 220, Imd. Eff. Jan. 5, 2010;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Compiler's note: In Plans K and L, a superscript numeral "1" has been substituted wherever a diamond symbol should occur.

Popular name: Act 218

500.3817 Medicare select policies and certificates; definitions; requirements for issuance; plan of operation; filing, format, and contents; proposed changes; updated list of network providers; payment for covered services not available through network providers;

disclosure; receipt of information; grievance procedure; report; availability of comparable or lesser benefits; continuation of coverage; requests for data by state or federal agencies.

Sec. 3817. (1) This section applies to medicare select policies and certificates.

(2) As used in this section:

(a) "Complaint" means any dissatisfaction expressed by an individual concerning a medicare select insurer or its network providers.

(b) "Grievance" means a dissatisfaction expressed in writing by an individual insured under a medicare select policy or certificate with the administration, claims practices, or provision of services concerning a medicare select insurer or its network providers.

(c) "Medicare select insurer" means an insurer offering, or seeking to offer, a medicare select policy or certificate.

(d) "Medicare select policy" or "medicare select certificate" means a medicare supplement policy or certificate that contains restricted network provisions.

(e) "Network provider" means a provider of health care, or a group of providers of health care, that has entered into a written agreement with the insurer to provide benefits under a medicare select policy or certificate.

(f) "Restricted network provision" means any provision that conditions the payment of benefits, in whole or in part, on the use of network providers.

(g) "Service area" means the geographic area approved by the commissioner within which an insurer is authorized to offer a medicare select policy or certificate.

(3) A policy or certificate shall not be advertised as a medicare select policy or certificate unless it meets the requirements of this section.

(4) The commissioner may authorize an insurer to offer a medicare select policy or certificate, pursuant to this section and section 1882 of part C of title XVIII of the social security act, 42 USC 1395ss, if the commissioner finds that the insurer has satisfied all necessary requirements.

(5) A medicare select insurer shall not issue a medicare select policy or certificate in this state until its plan of operation has been approved by the commissioner.

(6) A medicare select insurer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

(a) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, as follows:

(*i*) That services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(*ii*) That the number of network providers in the service area is sufficient, with respect to current and expected policyholders, either to deliver adequately all services that are subject to a restricted network provision or to make appropriate referrals.

(*iii*) That there are written agreements with network providers describing specific responsibilities.

(*iv*) That emergency care is available 24 hours per day and 7 days per week.

(*v*) That in the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a medicare select policy or certificate. This subparagraph does not apply to supplemental charges or coinsurance amounts as stated in the medicare select policy or certificate.

(b) A statement or map providing a clear description of the service area.

(c) A description of the grievance procedure to be used.

(d) A description of the quality assurance program, including all of the following:

(*i*) The formal organizational structure.

(*ii*) The written criteria for selection, retention, and removal of network providers.

(*iii*) The procedures for evaluating quality of care provided by network providers and the process to initiate corrective action if warranted.

(e) A list and description, by specialty, of the network providers.

(f) Copies of the written information proposed to be used by the insurer to comply with subsection (10).

(g) Any other information requested by the commissioner.

(7) A medicare select insurer shall file any proposed changes to the plan of operation, except for changes

to the list of network providers, with the commissioner prior to implementing any changes. An updated list of network providers shall be filed with the commissioner at least quarterly. Changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

(8) A medicare select policy or certificate shall not restrict payment for covered services provided by nonnetwork providers if the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or a condition and it is not reasonable to obtain such services through a network provider.

(9) A medicare select policy or certificate shall provide payment for full coverage under the policy or certificate for covered services that are not available through network providers.

(10) A medicare select insurer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the medicare select policy or certificate to each applicant. This disclosure shall include at least all of the following:

(a) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the medicare select policy or certificate with other medicare supplement policies or certificates offered by the insurer or offered by other insurers.

(b) A description, including address, phone number, and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.

(c) A description of the restricted network provisions, including payments for coinsurance and deductibles if providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L.

(d) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

(e) A description of limitations on referrals to restricted network providers and to other providers.

(f) A description of the policyholder's rights to purchase any other medicare supplement policy or certificate otherwise offered by the insurer.

(g) A description of the medicare select insurer's quality assurance program and grievance procedure.

(11) Prior to the sale of a medicare select policy or certificate, a medicare select insurer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subsection (10) and that the applicant understands the restrictions of the medicare select policy or certificate.

(12) A medicare select insurer shall have and use procedures for hearing complaints and resolving written grievances from subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures. The grievance procedure shall be described in the policy and certificate and in the outline of coverage. At the time the policy or certificate is issued, the insurer shall provide detailed information to the policyholder describing how a grievance may be registered with the insurer. Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action. If a grievance is found to be valid, corrective action shall be taken promptly. All concerned parties shall be notified about the results of a grievance. The insurer shall report no later than each March 31 to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of those grievances.

(13) At the time of initial purchase, a medicare select insurer shall make available to each applicant for a medicare select policy or certificate the opportunity to purchase any medicare supplement policy or certificate otherwise offered by the insurer.

(14) At the request of an individual insured under a medicare select policy or certificate, a medicare select insurer shall make available to the individual insured the opportunity to purchase a medicare supplement policy or certificate offered by the insurer that has comparable or lesser benefits and that does not contain a restricted network provision. The insurer shall make the policies or certificates available without requiring evidence of insurability after the medicare supplement policy or certificate has been in force for 6 months. For the purposes of this subsection, a medicare supplement policy or certificate shall be considered to have comparable or lesser benefits unless it contains 1 or more significant benefits not included in the medicare select policy or certificate being replaced. For the purposes of this subsection, a significant benefit means coverage for the medicare part A deductible, coverage for at-home recovery services, or coverage for part B excess charges.

(15) Medicare select policies and certificates shall provide for continuation of coverage if the secretary of health and human services determines that medicare select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the medicare select program to be reauthorized

under law or its substantial amendment. Each medicare select insurer shall make available to each individual insured under a medicare select policy or certificate the opportunity to purchase any medicare supplement policy or certificate offered by the insurer that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability. For the purposes of this subsection, a medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains 1 or more significant benefits not included in the medicare select policy or certificate being replaced. For the purposes of this subsection, a significant benefit means coverage for the medicare part A deductible, coverage for at-home recovery service, or coverage for part B excess charges.

(16) A medicare select insurer shall comply with reasonable requests for data made by state or federal agencies, including the United States department of health and human services, for the purposes of evaluating the medicare select program.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006.

Popular name: Act 218

500.3819 Minimum standards; suspension of benefits and premiums; notice; reinstitution; offer to exchange 1990 standardized plan to 2010 plan.

Sec. 3819. (1) An insurance policy shall not be titled, advertised, solicited, or issued for delivery in this state as a medicare supplement policy if the policy does not meet the minimum standards prescribed in this section. These minimum standards are in addition to all other requirements of this chapter.

(2) The following standards apply to medicare supplement policies:

(a) A medicare supplement policy shall not deny a claim for losses incurred more than 6 months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than to mean 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.

(b) A medicare supplement policy shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(c) A medicare supplement policy 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.

(d) A medicare supplement policy shall be guaranteed renewable. Termination shall be for nonpayment of premium or material misrepresentation only.

(e) Termination of a medicare supplement policy shall not reduce or limit the payment of benefits for any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated 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.

(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, Public Law 108-173, the modified policy shall be considered to satisfy the guaranteed renewal of this subsection.

(g) A medicare supplement policy shall not 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.

(3) A medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder or certificate holder for a period not to exceed 24 months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under medicaid, but only if the policyholder or certificate holder notifies the insurer of such assistance within 90 days after the date the individual becomes entitled to the assistance. Upon receipt of timely notice, the insurer shall return to the policyholder or certificate holder that portion of the premium attributable to the period of medicaid eligibility, subject to adjustment for paid claims. If a suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance under medicaid, the policy shall be automatically reinstituted effective as of the date of termination of the assistance if the policyholder or certificate holder provides notice of loss of medicaid medical assistance within 90 days after the date of the loss and pays the premium attributable to the period effective as of the date of termination of the assistance. Each medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of

title II of the social security act, and is covered under a group health plan as defined in section 1862(b)(1)(A)(*v*) of the social security act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted effective as of the date of loss of coverage if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan. All of the following apply to the reinstitution of a medicare supplement policy under this subsection:

(a) The reinstitution shall not provide for any waiting period with respect to treatment of preexisting conditions.

(b) Reinstituted coverage shall be 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 the suspension.

(c) Classification of premiums for reinstituted coverage shall be on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(4) If an insurer makes a written offer to the medicare supplement policyholders or certificate holders of 1 or more of its plans, to exchange during a specified period from his or her 1990 standardized plan to a 2010 standardized plan, the offer and subsequent exchange shall comply with the following requirements:

(a) An insurer need not provide justification to the commissioner 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 that time of that offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the prefunding 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 commissioner.

(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 insurer may not apply new preexisting 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 preexisting 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 certificate holders within a given plan, except where the offer or issue would be in violation of state or federal law.

(5) This section applies to medicare supplement policies or certificates delivered or issued for delivery with an effective date for coverage prior to June 1, 2010.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006;—Am. 2009, Act 220, Imd. Eff. Jan. 5, 2010.

Popular name: Act 218

500.3819a Medicare supplement policies or certificates with effective date for coverage on or after June 1, 2010; minimum standards.

Sec. 3819a. (1) This section applies to all Medicare supplement policies or certificates delivered or issued for delivery with an effective date for coverage on or after June 1, 2010.

(2) An insurance policy must not be titled, advertised, solicited, or issued for delivery in this state as a Medicare supplement policy if the policy does not meet the minimum standards prescribed in this section. These minimum standards are in addition to all other requirements of this chapter. An issuer shall not offer any 1990 plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of section 3819.

(3) The following standards apply to Medicare supplement policies:

(a) A Medicare supplement policy must not deny a claim for losses incurred more than 6 months from the effective date of coverage because it involved a preexisting condition. The policy or certificate must not define a preexisting condition more restrictively than to mean 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.

(b) A Medicare supplement policy must not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(c) A Medicare supplement policy must 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.

(d) A Medicare supplement policy must be guaranteed renewable. Termination must be for nonpayment of premium or material misrepresentation only.

(e) Termination of a Medicare supplement policy must not reduce or limit the payment of benefits for any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated on 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.

(f) A Medicare supplement policy must not 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.

(4) A Medicare supplement policy must provide that benefits and premiums under the policy will be suspended at the request of the policyholder or certificate holder for a period not to exceed 24 months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Medicaid, but only if the policyholder or certificate holder notifies the insurer of the assistance within 90 days after the date the individual becomes entitled to the assistance. On receipt of timely notice, the insurer shall return to the policyholder or certificate holder that portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims. If a suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance under Medicaid, the policy must be automatically reinstituted effective as of the date of termination of the assistance if the policyholder or certificate holder provides notice of loss of Medicaid medical assistance within 90 days after the date of the loss and pays the premium attributable to the period effective as of the date of termination of the assistance. A Medicare supplement policy must provide that benefits and premiums under the policy will be suspended at the request of the policyholder if the policyholder is entitled to benefits under 42 USC 426(b), and is covered under a group health plan as defined in 42 USC 1395y(b)(1)(a)(*v*). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy must be automatically reinstituted effective as of the date of loss of coverage if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan. All of the following apply to the reinstitution of a Medicare supplement policy under this subsection:

(a) The reinstitution must not provide for any waiting period with respect to treatment of preexisting conditions.

(b) Reinstituted coverage must be substantially equivalent to coverage in effect before the date of the suspension.

(c) Classification of premiums for reinstituted coverage must be on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

History: Add. 2009, Act 220, Imd. Eff. Jan. 5, 2010;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3821 Issuance of policy to person not enrolled in medicare parts A and B prohibited; refund; interest.

Sec. 3821. (1) An insurer shall not issue an individual medicare supplement policy to a person who has not applied for or enrolled in medicare, parts A and B. If it is later determined that a person has not applied for or enrolled in medicare, parts A and B, an insurer shall refund all premiums received from the person for a medicare supplement policy issued to the person plus interest less the amount of any benefits received by the person under the policy.

(2) Interest under subsection (1) shall be calculated at 6-month intervals from the date the first premium payment was received at a rate of interest equal to 1% plus the average interest rate paid at auctions of 5-year United States treasury notes during the 6 months immediately preceding July 1 and January 1, as certified by the state treasurer, and compounded annually.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3823 Covered benefits more restrictive than benefits under medicare and required under state law prohibited; benefits for outpatient prescription drugs.

Sec. 3823. (1) An insurance policy shall not be titled, advertised, solicited, or issued for delivery in this state as a medicare supplement policy unless the definitions and terms contained in the policy are such that covered benefits under the policy are not more restrictive than covered benefits under medicare and those required to be provided under state law.

(2) A medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 shall be renewed for current policyholders who do not enroll in part D at the option of the policyholder.

(3) A medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

(4) After December 31, 2005, a medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in medicare part D unless:

(a) The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a part D plan.

(b) Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of medicare part D enrollment, accounting for any claims paid, if applicable.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006.

Popular name: Act 218

500.3825 Preexisting diseases or conditions; waiver prohibited.

Sec. 3825. A medicare supplement policy shall not use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3827 Duplicate benefits prohibited; application; statements and questions whether another policy in force; list of policies sold to applicant; notice regarding replacement coverage.

Sec. 3827. (1) A Medicare supplement insurance policy or certificate must not be delivered or issued for delivery in this state if the policy or certificate provides benefits that duplicate benefits provided by Medicare.

(2) Application forms or a supplementary application or other form to be signed by the applicant and agent for Medicare supplement policies, which may be provided in written or electronic format, must include the following statements and questions designed to inform and elicit information as to whether, on the date of the application, the applicant has Medicare supplement, Medicare advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any health policy or certificate presently in force:

[STATEMENTS]

(1) You do not need more than 1 Medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy will be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days after becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy, or, if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days after losing Medicaid eligibility. If the Medicare supplement provided coverage for outpatient prescription drugs and you enrolled in Medicare part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy, or if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days after losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare part D

while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning Medicaid.

[QUESTIONS]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark Yes or No below with an "X"]

To the best of your knowledge,

(1) (a) Did you turn age 65 in the last 6 months?
Yes ____ No ____

(b) Did you enroll in Medicare part B in the last 6 months?
Yes ____ No ____

(c) If yes, what is the effective date? _____

(2) Are you covered for medical assistance through the state Medicaid program?
[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]
Yes ____ No ____

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy?
Yes ____ No ____

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare part B premium?
Yes ____ No ____

(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
START __/__/__ END __/__/__

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?
Yes ____ No ____

(c) Was this your first time in this type of Medicare plan?
Yes ____ No ____

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?
Yes ____ No ____

(4) (a) Do you have another Medicare supplement policy in force?
Yes ____ No ____

(b) If so, with what company, and what plan do you have [optional for direct mailers]?
_____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?
Yes ____ No ____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes ____ No ____

(a) If so, with what company and what kind of policy?

_____

_____

_____

_____

(b) What are your dates of coverage under the other policy?

START __/__/__ END __/__/__

(If you are still covered under the other policy, leave "END" blank.)

(3) An agent shall list on the application form for a Medicare supplement policy any other health insurance policies, certificates, or contracts he or she has sold to the applicant, including policies, certificates, or contracts sold that are still in force and policies, certificates, and contracts sold in the past 5 years that are no longer in force.

(4) For a direct response insurer, the insurer shall return a copy of the application or supplement form, signed by the applicant, and acknowledged by the insurer, to the applicant on delivery of the policy or certificate.

(5) On determining that a sale will involve replacement of Medicare supplement coverage, an insurer, other than a direct response insurer or its agent, shall furnish the applicant before issuance or delivery of the Medicare supplement policy the following notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, unless the coverage is sold without an agent, must be provided to the applicant and an additional signed copy must be retained by the insurer. A direct response insurer shall deliver to the applicant at the time of issuance of the policy or certificate the following notice, regarding replacement of Medicare supplement coverage. The notice regarding replacement of Medicare supplement coverage must be provided in substantially the following form and in not less than 12-point type:

"NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE ADVANTAGE
(INSURANCE COMPANY'S NAME AND ADDRESS)
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to (your application) (information you have furnished), you intend to drop or otherwise terminate existing Medicare supplement coverage or Medicare advantage plan and replace it with a policy or certificate to be issued by (company name) insurance company. Your new policy or certificate provides 30 days within which you may decide without cost whether you desire to keep the policy or certificate.

You should review this new coverage carefully comparing it with all disability and other health coverage you now have and terminate your present coverage only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

Statement to applicant by insurer, agent, or other representative:

(Use additional sheets as necessary.)

I have reviewed your current medical or health coverage. The replacement of coverage involved in this transaction does not duplicate your existing Medicare supplement, or, if applicable, Medicare advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare advantage plan, to the best of my knowledge. The replacement policy is being purchased for the following reasons (check 1):

_____ Additional benefits

_____ No change in benefits, but lower premiums

_____ Fewer benefits and lower premiums

_____ My plan has outpatient prescription drug coverage and I am enrolling in part D

_____ Disenrollment from a Medicare advantage plan. Please explain reason for disenrollment. [Optional only for direct mailers.]

_____ Other. (Please specify)

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy. This paragraph may be deleted by an insurer if the replacement does not involve application of a new pre-existing condition limitation.

2. Your insurer will waive any time periods applicable to preexisting conditions, waiting periods,

elimination periods, or probationary periods in the new policy or certificate for similar benefits to the extent such time was spent or depleted under the original coverage. This paragraph may be deleted by an insurer if the replacement does not involve application of a new preexisting condition limitation.

3. If, after thinking about it carefully, you still wish to drop your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the insurer to deny any future claims and to refund your premium as though your policy or certificate had never been in force. After the application has been completed, and before you sign it, review it carefully to be certain that all information has been properly recorded. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

4. Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____

Signature of Agent, Broker, or Other Representative
(* Signature not required for direct response sales.)

_____

Typed Name and Address of Agent or Broker

_____

(Date)

The above "Notice to Applicant" was delivered to me on:

_____

(Date)

_____

(Applicant's Signature)

_____

(Applicant's Printed Name)

_____

(Applicant's Address)

(Policy, Certificate, or Contract Number being Replaced)"

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3829 Denying or conditioning issuance based on health status, claims experience, receipt of health care, or medical condition of applicant prohibited; condition; exclusion of benefits based on preexisting conditions; reduction; creditable coverage.

Sec. 3829. (1) An insurer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy available for sale in this state, or discriminate in the pricing of such a policy, because of the health status, claims experience, receipt of health care, or medical condition of an applicant if an application for the policy is submitted during the 6-month period beginning with the first month in which an individual who is 65 years of age or older enrolled for benefits under Medicare part B. Each Medicare supplement policy currently available from an insurer must be made available to all applicants who qualify under this section without regard to age.

(2) If an applicant qualifies under subsection (1), submits an application during the time period provided in subsection (1), and as of the date of application has had a continuous period of creditable coverage of not less than 6 months, the insurer shall not exclude benefits based on a preexisting condition. If the applicant qualifies under subsection (1), submits an application during the time period in subsection (1), and as of the date of application has had a continuous period of creditable coverage that is less than 6 months, the insurer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this subsection.

(3) Except as provided in subsection (2) and section 3833, subsection (1) does not prevent the exclusion of benefits under a policy, during the first 6 months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the 6 months before the coverage became effective.

(4) As used in this section, "creditable coverage" does not include any of the following:

(a) One or more of the following:

(*i*) Coverage only for accident or disability income insurance, or any combination of accident or disability income insurance.

(*ii*) Coverage issued as a supplement to liability insurance.

(*iii*) Liability insurance, including general liability insurance and automobile liability insurance.

(*iv*) Workers' compensation or similar insurance.

(*v*) Automobile medical payment insurance.

(*vi*) Credit-only insurance.

(*vii*) Coverage for on-site medical clinics.

(*viii*) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(b) The following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(*i*) Limited scope dental or vision benefits.

(*ii*) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination of long-term care, nursing home care, home health care, or community-based care.

(*iii*) Such other similar, limited benefits as are specified in federal regulations.

(c) The following benefits if offered as independent, noncoordinated benefits:

(*i*) Coverage only for a specified disease or illness.

(*ii*) Hospital indemnity or other fixed indemnity insurance.

(d) The following if it is offered as a separate policy, certificate, or contract of insurance:

(*i*) Medicare supplemental policy as defined in 42 USC 1395ss.

(*ii*) Coverage supplemental to the coverage provided under chapter 55 of title 10 of the United States Code, 10 USC 1071 to 1110b.

(*iii*) Similar supplemental coverage provided to coverage under a group health plan.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3829a Medicare supplement policies or certificates delivered, issued for delivery, or renewed on or after May 21, 2009; genetic test; definitions.

Sec. 3829a. (1) This section applies to all medicare supplement policies or certificates delivered, issued for delivery, or renewed on or after May 21, 2009.

(2) An insurer of a medicare supplement policy or certificate shall not do either of the following:

(a) Deny or condition the issuance or effectiveness of the policy or certificate, including the imposition of any exclusion of benefits under the policy based on a preexisting condition, on the basis of the genetic information with respect to that individual.

(b) Discriminate in the pricing of the policy or certificate, including the adjustment of premium rates, of an individual on the basis of the genetic information with respect to that individual.

(3) Nothing in subsection (2) limits the ability of an insurer, to the extent otherwise permitted by law, from doing either of the following:

(a) Denying or conditioning the issuance or effectiveness of a policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant.

(b) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy. However, the manifestation of a disease or disorder in 1 individual cannot be used as genetic information about other group members and to further increase the premium for the group.

(4) An insurer of a medicare supplement policy or certificate shall not request or require an individual or a family member of that individual to undergo a genetic test.

(5) Subsection (4) does not preclude an insurer of a medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment, as defined for the purposes of applying the regulations promulgated under part C of title XI and section 264 of the health insurance portability and accountability act of 1996, 42 USC 1320d to 1320d-8, and consistent with subsection (2).

(6) For purposes of carrying out subsection (5), an insurer of a medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

(7) Notwithstanding subsection (4), an insurer of a medicare supplement policy may request, but not require, that an individual, or a family member of that individual, undergo a genetic test if each of the following conditions is met:

(a) The request is made pursuant to research that complies with 45 CFR part 46, or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in

research.

(b) The insurer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of that child, to whom the request is made, that compliance with the request is voluntary and that noncompliance will have no effect on enrollment status or premium or contribution amounts.

(c) Genetic information collected or acquired under this subsection shall not be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

(d) The insurer notifies the commissioner in writing that the insurer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted.

(e) The insurer complies with any other conditions as the commissioner may by regulation require for activities conducted under this subsection.

(8) An insurer of a medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

(9) An insurer of a medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to that individual's enrollment under the policy in connection with that enrollment.

(10) If an insurer of a medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, that request, requirement, or purchase is not a violation of subsection (9) if that request, requirement, or purchase does not violate subsection (8).

(11) As used in this section:

(a) "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of that individual.

(b) "Genetic information" means, with respect to any individual, information about that individual's genetic tests, the genetic tests of family members of that individual, and the manifestation of a disease or disorder in family members of that individual. Genetic information includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by that individual or any family member of that individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman includes genetic information of any fetus carried by that pregnant woman or, with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. Genetic information does not include information about the sex or age of any individual.

(c) "Genetic services" means a genetic test, genetic counseling, including obtaining, interpreting, or assessing genetic information, or genetic education.

(d) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. Genetic test does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(e) "Insurer of a medicare supplement policy or certificate" includes a third-party administrator or other person acting for or on behalf of that insurer.

(f) "Underwriting purposes" means all of the following:

(*i*) Rules for, or determination of, eligibility, including enrollment and continued eligibility, for benefits under the policy.

(*ii*) The computation of premium or contribution amounts under the policy.

(*iii*) The application of any preexisting condition exclusion under the policy.

(*iv*) Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

History: Add. 2009, Act 219, Imd. Eff. Jan. 5, 2010.

Popular name: Act 218

500.3830 Eligible person; requirements.

Sec. 3830. (1) An eligible person is an individual described in subsection (2) who applies to enroll under a medicare supplement policy during the period described in subsection (3), and who submits evidence of the date of termination or disenrollment or medicare part D enrollment with the application for a medicare supplement policy. For an eligible person, an insurer shall not deny or condition the issuance or effectiveness of a medicare supplement policy described in subsections (5), (6), and (7) that is offered and is available for

issuance to new enrollees by the insurer, shall not discriminate in the pricing of the medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under the medicare supplement policy.

(2) An eligible person under this section is an individual that meets any of the following:

(a) Is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under medicare and the plan terminates or the plan ceases to provide all those supplemental health benefits to the individual.

(b) Is enrolled with a medicare advantage organization under a medicare advantage plan under part C of medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a PACE provider under section 1894 of the social security act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a medicare advantage plan:

(*i*) The certification of the organization or plan has been terminated.

(*ii*) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

(*iii*) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(b) of the social security act, where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards established under section 1856 of the social security act, or the plan is terminated for all individuals within a residence area.

(*iv*) The individual demonstrates, in accordance with guidelines established by the secretary, that the organization offering the plan substantially violated a material provision of the organization's contract in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide covered care in accordance with applicable quality standards, or the organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual.

(*v*) The individual meets other exceptional conditions as the secretary may provide.

(c) Is enrolled with an eligible organization under a contract under section 1876 of the social security act, a similar organization operating under demonstration project authority, effective for periods before April 1, 1999, an organization under an agreement under section 1833(a)(1)(A) of the social security act, health care prepayment plan, or an organization under a medicare select policy, and the enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under subdivision (b).

(d) Is enrolled under a medicare supplement policy and the enrollment ceases because of any of the following:

(*i*) The insolvency of the insurer or bankruptcy of the noninsurer organization or of other involuntary termination of coverage or enrollment under the policy.

(*ii*) The insurer substantially violated a material provision of the policy.

(*iii*) The insurer, or an agent or other entity acting on the insurer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.

(e) Was enrolled under a medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any medicare advantage organization under a medicare advantage plan under part C of medicare, any eligible organization under a contract under section 1876 of the social security act, medicare cost, any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the social security act, or a medicare select policy; and the subsequent enrollment is terminated by the enrollee during any period within the first 12 months of the subsequent enrollment during which the enrollee is permitted to terminate the subsequent enrollment under section 1851(e) of the social security act.

(f) Upon first becoming eligible for benefits under part A of medicare at age 65, enrolls in a medicare advantage plan under part C of medicare, or with a PACE provider under section 1894 of the social security act, and disenrolls from the plan or program by not later than 12 months after the effective date of enrollment.

(g) Enrolls in a medicare part D plan during the initial enrollment period and, at the time of enrollment in part D, was enrolled under a medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the medicare supplement policy and submits evidence of enrollment in medicare part D along with the application for a policy described in subsection (5).

(3) The guaranteed issue time periods under this section are as follows:

(a) For an individual described in subsection (2)(a), the guaranteed issue time period begins on the date the individual receives a notice of termination or cessation of all supplemental health benefits or, if a notice is not

received, notice that a claim has been denied because of a termination or cessation, or the date that the applicable coverage terminates or ceases, whichever occurs later, and ends 63 days after that date.

(b) For an individual described in subsection (2)(b), (c), (e), or (f) whose enrollment is terminated involuntarily, the guaranteed issue time period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

(c) For an individual described in subsection (2)(d)(*i*), the guaranteed issue time period begins on the earlier of the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice, if any, or the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.

(d) For an individual described in subsection (2)(b), (d)(*ii*), (d)(*iii*), (e), or (f) who disenrolls voluntarily, the guaranteed issue time period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date.

(e) In the case of an individual described in subsection (2)(g), the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the social security act from the medicare supplement issuer during the 60-day period immediately preceding the initial part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under medicare part D.

(f) For an individual described in subsection (2) but not described in subdivisions (a) to (d), the guaranteed issue time period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

(4) For an individual described in subsection (2)(e) whose enrollment with an organization or provider described in subsection (2)(e) is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be considered an initial enrollment described in subsection (2)(e). For an individual described in subsection (2)(f) whose enrollment within a plan or in a program described in subsection (2)(f) is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be considered an initial enrollment described in subsection (2)(f). For purposes of subsections (2)(e) and (f), an enrollment of an individual with an organization or provider described in subsection (2)(e), or with a plan or provider described in subsection (2)(f), shall not be considered to be an initial enrollment after the 2-year period beginning on the date on which the individual first enrolled with such an organization, provider, or plan.

(5) Subject to this subsection, the medicare supplement policy to which an eligible person is entitled under subsection (2)(a), (b), (c), and (d) is a medicare supplement policy that has a benefit package classified as plan A, B, C, or F including F with a high deductible, K, or L offered by any insurer. After December 31, 2005, if the individual was most recently enrolled in a medicare supplement policy with an outpatient prescription drug benefit, a medicare supplement policy described in this subsection is:

(a) The policy available from the same insurer but modified to remove outpatient prescription drug coverage.

(b) At the election of the policyholder, an A, B, C, F, including F with a high deductible, K, or L policy that is offered by any insurer.

(6) The medicare supplement policy to which an eligible person is entitled under subsection (2)(e) is the same medicare supplement policy in which the individual was most recently previously enrolled, if available from the same insurer, or, if not so available, a policy described in subsection (5).

(7) The medicare supplement policy to which an eligible person is entitled under subsection (2)(f) shall include any medicare supplement policy offered by any insurer.

(8) Subsection (2)(g) is a medicare supplement policy that has a benefit package classified as plan A, B, C, F, including F with a high deductible, K, or L, and that is offered and is available for issuance to new enrollees by the same insurer that issued the individual's medicare supplement policy with outpatient prescription drug coverage.

History: Add. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006.

Popular name: Act 218

500.3830a Termination of contract or agreement; notice to individual.

Sec. 3830a. (1) At the time of an event described in section 3830(2) because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the insurer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under section 3830 and of the obligations of insurers of medicare supplement policies under section 3830(1). The notice shall be

communicated contemporaneously with the notification of termination.

(2) At the time of an event described in section 3830(2) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the insurer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under section 3830 and of the obligations of insurers of medicare supplement policies under section 3830(1). The notice shall be communicated within 10 working days of the insurer receiving notification of disenrollment.

History: Add. 2002, Act 304, Imd. Eff. May 10, 2002.

Popular name: Act 218

500.3831 Individual or group expense incurred hospital, medical, or surgical policies; right of continuation or conversion to medicare supplemental plan; request for coverage; exclusion from preexisting conditions; notice of availability of coverage; utilization of another insurer to write coverage.

Sec. 3831. (1) Each insurer offering group expense incurred hospital, medical, or surgical policies or certificates in this state shall make available without restriction, to any person who requests coverage from an insurer and has been insured with an insurer, if the person loses coverage under a group policy after becoming eligible for Medicare, a right of continuation or conversion to 1 of the following Medicare supplement plans that is guaranteed renewable or noncancellable:

(a) A policy form or certificate form that contains the basic core benefits as described in section 3807 or 3807a.

(b) A policy form or certificate form that the insurer has chosen to offer that contains either standardized benefit plan C or standardized benefit plan F. For an individual newly eligible for Medicare after December 31, 2019, any reference to standardized benefit plan C or standardized benefit plan F is deemed a reference to Medicare supplement standardized benefit plan D or Medicare supplement standardized benefit plan G, respectively.

(2) A person who is hospitalized or has been informed by a physician that he or she will require hospitalization within 30 days after the time of application is not entitled to coverage under subsection (1) until the day following the date of discharge. However, if the hospitalized person was insured by the insurer immediately before losing coverage under a group policy after becoming eligible for Medicare, the person is eligible for immediate coverage from the previous insurer under subsection (1). A person is not entitled to a Medicare supplemental policy under subsection (1) unless the person presents satisfactory proof to the insurer that he or she was insured with an insurer subject to this section. A person who wishes coverage under subsection (1) must request coverage within 180 days after losing coverage under a group policy. A person 60 years of age or older who loses coverage under a group policy is entitled to coverage under a Medicare supplemental policy without restriction from the insurer providing the former group coverage, if he or she requests coverage within 90 days before or 90 days after the month he or she becomes eligible for Medicare.

(3) Except as provided in section 3833, a person not insured under a group hospital, medical, or surgical expense incurred policy as specified in subsection (1), after applying for coverage under a Medicare supplemental policy required to be offered under subsection (1), is entitled to coverage under a Medicare supplemental policy that may include a provision for exclusion from preexisting conditions for 6 months after the inception of coverage, consistent with the provisions of section 3819(2)(a) or 3819a(3)(a).

(4) Each group policyholder providing hospital, medical, or surgical expense incurred coverage in this state shall give to each certificate holder who is covered at the time he or she becomes eligible for Medicare, written notice of the availability of coverage under this section.

(5) Notwithstanding the requirements of this section, an insurer offering or renewing group expense incurred hospital, medical, or surgical policies or certificates after June 27, 2005 may comply with the requirement of providing Medicare supplemental coverage to eligible policyholders by utilizing another insurer to write this coverage if the insurer meets all of the following requirements:

(a) The insurer provides its policyholders the name of the insurer that will provide the Medicare supplemental coverage.

(b) The insurer gives its policyholders the telephone numbers at which the Medicare supplemental insurer can be reached.

(c) The insurer remains responsible for providing Medicare supplemental coverage to its policyholders if the other insurer no longer provides coverage and another insurer is not found to take its place.

(d) The insurer provides certification from an executive officer for the specific insurer or affiliate of the insurer wishing to utilize this option. This certification must identify the process provided in subdivisions (a)

to (c) and must clearly state that the insurer understands that the director may void this arrangement if the affiliate fails to ensure that eligible policyholders are immediately offered Medicare supplemental policies.

(e) If the insurer is unable to meet the requirements of subdivisions (a) to (d), the insurer certifies to the director that it is in the process of discontinuing in this state its offering of individual or group expense incurred hospital, medical, or surgical policies or certificates.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006;—Am. 2009, Act 220, Imd. Eff. Jan. 5, 2010;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3833 Replacement policy; waiver of certain time periods.

Sec. 3833. If a medicare supplement policy or certificate replaces another medicare supplement policy, certificate, or contract, the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new medicare supplement policy for similar benefits to the extent such time was spent under the original coverage.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3835 Marketing procedures; determining appropriateness of recommended purchase or replacement; more than 1 policy prohibited; individual enrolled in medicare advantage; "notice to buyer" displayed.

Sec. 3835. (1) An insurer that markets Medicare supplement insurance coverage in this state directly or through its agents shall do all of the following:

(a) Establish marketing procedures to ensure that any comparison of policies by its agents will be fair and accurate.

(b) Establish marketing procedures to ensure excessive insurance is not sold or issued.

(c) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant for Medicare supplement insurance already has health coverage.

(d) Establish auditable procedures for verifying compliance with this subsection.

(2) In recommending the purchase or replacement of any Medicare supplement coverage, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(3) Any sale of Medicare supplement coverage that will provide an individual with more than 1 Medicare supplement policy, certificate, or contract is prohibited.

(4) An insurer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare advantage unless the effective date of the coverage is after the termination date of the individual's Medicare advantage coverage.

(5) A medical supplement policy must display prominently by type, stamp, or other appropriate means, on the first page of the policy the following: "Notice to buyer: This policy may not cover all of your medical expenses.".

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3837 Repealed. 2002, Act 304, Imd. Eff. May 10, 2002.

Compiler's note: The repealed section pertained to report to commissioner.

Popular name: Act 218

500.3839 Renewal or continuation provision; effect of termination or replacement; elimination of outpatient prescription drug benefit.

Sec. 3839. (1) Each medicare supplement policy shall include a renewal or continuation provision. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the term of coverage for which the policy is issued and for which it may be renewed. The provision shall include any reservation by the insurer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) If a medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subsection (4), the issuer shall offer certificate holders an individual medicare supplement policy that at the option of the certificate holder provides for continuation of the benefits contained in the group policy or provides for such benefits as otherwise meet the requirements of section 3819 or 3819a.

(3) If an individual is a certificate holder in a group medicare supplement policy and the individual

terminates membership in the group, the issuer shall offer the certificate holder the conversion opportunity described in subsection (2) or (4) or at the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(4) If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group 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.

(5) 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, Public Law 108-173, the modified policy shall be considered to satisfy the guaranteed renewal requirements of this section.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006;—Am. 2009, Act 220, Imd. Eff. Jan. 5, 2010.

Popular name: Act 218

500.3841 Riders or endorsements; signed acceptance or agreement; additional premium; use of certain standards, terms, and words; filing of changes in medicare benefits; elimination of duplicate benefits; notice of modifications; notice requirements of medicare prescription drug, improvement, and modernization act of 2003.

Sec. 3841. (1) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured, exercises a specifically reserved right under a medicare supplement policy, or as required to reduce or eliminate benefits to avoid duplication of medicare benefits, all riders or endorsements added to a medicare supplement policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the insured. After the date of policy issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing and signed by the insured, unless the benefits are required minimum standards for medicare supplement policies or if the increase in benefits or coverage is required by law. If a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charged shall be set forth in the policy.

(2) A medicare supplement policy shall not provide for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or words of similar import.

(3) If a medicare supplement policy contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy and shall be labeled as "preexisting condition limitations".

(4) The term "medicare supplement", "medigap", "medicare wrap-around", or words of similar import shall not be used unless the policy is issued in compliance with this chapter.

(5) As soon as practicable but prior to the effective date of any changes in medicare benefits, every insurer offering medicare supplement insurance policies in this state shall file with the commissioner both of the following:

(a) Any appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies and any supporting documents necessary to justify the adjustment.

(b) Any appropriate riders, endorsements, or policy forms needed to accomplish the medicare supplement insurance modifications necessary to eliminate benefits under the policy or certificate that duplicate benefits provided by medicare. The riders, endorsements, and policy forms shall provide a clear description of the medicare supplement benefits provided by the policy.

(6) Upon satisfying the filing and approval requirements, an insurer providing medicare supplement policies delivered or issued for delivery in this state shall provide to each covered policyholder any rider, endorsement, or policy form necessary to eliminate benefits under the policy that duplicate benefits provided by medicare.

(7) As soon as practicable but no later than 30 days before the annual effective date of any medicare benefit changes, every insurer of medicare supplement policies delivered or issued for delivery in this state shall notify each covered policyholder or certificate holder of modifications made to its medicare supplement policies in a format acceptable to the commissioner. The notice shall be in outline form, contain clear and simple language, shall not contain or be accompanied by any solicitation, and shall include both of the following:

(a) A description of revisions to the medicare program and of each modification made to the coverage provided under the medicare supplement policy.

(b) Whether a premium adjustment is due to changes in medicare.

(8) Insurers shall comply with any notice requirements of the medicare prescription drug, improvement, and modernization act of 2003, Public Law 108-173.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006.

Popular name: Act 218

500.3843 Health insurance; notice; contents; applicability of subsection (1).

Sec. 3843. (1) A policy or certificate of health insurance issued for delivery in this state to persons eligible for Medicare by reason of age must notify insureds under the policy or certificate that the policy is not a Medicare supplement policy. The notice must either be printed or attached to the first page of the coverage outline delivered to insureds under the policy or certificate or, if a coverage outline is not delivered, to the first page of the policy or certificate delivered to insureds. The notice must be in not less than 12-point type, and must contain the following language:

"This (policy or certificate) is not a Medicare supplement (policy or certificate). It is not designed to fit with Medicare. It may not fit all of the gaps in Medicare and it may duplicate some Medicare benefits. If you are eligible for Medicare, review the Medicare supplement buyer's guide available from the company. If you decide to consider buying this policy or certificate, be sure you understand what it covers, what it does not cover, and whether it duplicates coverage you already have."

(2) Subsection (1) does not apply to any of the following:

(a) A Medicare supplement policy or certificate.

(b) A disability income policy or certificate.

(c) A single premium nonrenewable policy or certificate.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3847 Advertising; filing copy with director.

Sec. 3847. An insurer that provides Medicare supplement insurance coverage in this state shall file with the director for review a copy of any written, radio, or television advertisement for Medicare supplement insurance intended for use in this state at least 30 days before the date the insurer desires to use the advertising. The filing must include a sample or photocopy of all applicable Medicare supplement policies and related forms and the approval status of the policies and forms.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218

500.3849 Filing and approval requirements; deletion of outpatient prescription drug benefits; issuance of policy; use and change in premium rates; additional forms; availability; conditions and effect of discontinuance; combining forms for purposes of refund or credit calculation; compliance with federal law; “type” defined.

Sec. 3849. (1) An insurer shall not deliver or issue for delivery a medicare supplement policy to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

(2) An insurer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the medicare prescription drug, improvement, and modernization act of 2003, Public Law 108-173, only with the commissioner in the state in which the policy or certificate was issued.

(3) An insurer shall not use or change premium rates for a medicare supplement policy unless the rates, rating schedule, and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

(4) Except as provided in subsection (5), an insurer shall not file for approval more than 1 form of a policy or certificate for each individual policy and group policy standard medicare supplement benefit plan.

(5) With the approval of the commissioner, an issuer may offer up to 4 additional policy forms or certificate forms of the same type for the same standard medicare supplement benefit plan, 1 for each of the following cases:

(a) The inclusion of new or innovative benefits.

(b) The addition of either direct response or agent marketing methods.

(c) The addition of either guaranteed issue or underwritten coverage.

(d) The offering of coverage to individuals eligible for medicare by reason of disability.

(6) Except as provided in subsection (7), an insurer shall continue to make available for purchase any

medicare supplement policy form or certificate form issued after the effective date of this chapter that has been approved by the commissioner. A medicare supplement policy form or certificate form shall not be considered to be available for purchase unless the insurer has actively offered it for sale in the previous 12 months.

(7) An insurer may discontinue the availability of a medicare supplement policy form or certificate form if the insurer provides to the commissioner in writing its decision to discontinue at least 30 days prior to discontinuing the availability of the form of the medicare supplement policy. After receipt of the notice by the commissioner, the insurer shall no longer offer for sale the medicare supplement policy form or certificate form in this state.

(8) An insurer that discontinues the availability of a medicare supplement policy form or certificate form pursuant to subsection (7) shall not file for approval a new medicare supplement policy form or certificate form of the same type for the same standard medicare supplement benefit plan as the discontinued form for a period of 5 years after the insurer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

(9) The sale or other transfer of medicare supplement business to another insurer shall be considered a discontinuance for the purposes of this section. In addition, a change in the rating structure or methodology shall be considered a discontinuance under this section unless the insurer complies with the following requirements:

(a) The insurer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing methodology and existing rates.

(b) The insurer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential that is in the public interest.

(10) The experience of all medicare supplement policy forms or certificate forms of the same type in a standard medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in section 3853 except that forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

(11) Each insurer that issues medicare supplement policies for delivery in this state shall comply with sections 1842 and 1882 of title XVIII of the social security act, 42 USC 1395u and 1395ss, and shall certify that compliance on the medicare supplement insurance experience reporting form.

(12) For the purposes of this section, "type" means an individual policy, a group policy, an individual medicare select policy, or a group medicare select policy.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006.

Popular name: Act 218

500.3851 Aggregate benefits; rates, rating schedules, and rate revisions.

Sec. 3851. (1) A medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits, not including anticipated refunds or credits, the following:

(a) For group policies at least 75% of the aggregate amount of premiums earned calculated on the basis of incurred claims experience and earned premiums for the entire period for which rates are computed and in accordance with accepted actuarial principles and practices.

(b) For individual policies at least 65% of the aggregate amount of premium earned calculated on the basis of incurred claims experience and earned premiums for the entire period for which rates are computed and in accordance with accepted actuarial principles and practices.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3852 Benchmark ratio.

Sec. 3852. An insurer shall file by May 31 of each year a reporting form for the calculation of benchmark ratio since inception in a format prescribed by the commissioner for each type in a standard medicare

supplement benefit plan.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3853 Refund or credit calculation; form; interest; due date.

Sec. 3853. If on the basis of the experience as reported by an insurer under section 3852 the benchmark ratio since inception (ratio 1) exceeds the adjusted experienced ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis on a refund calculation form in a format prescribed by the commissioner for each type in a standard medicare supplement benefit plan. For purposes of the refund or credit calculation, only experience on policies issued within the reporting year shall be excluded. A refund or credit shall be made only where the benchmark loss ratio exceeds the adjusted experienced loss ratio and the amount to be refunded or credited exceeds the minimum level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of health and human services, but not less than the average rate of interest for 13-week treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3855 Annual filing of rates, rating schedule, and supporting documentation; premium adjustments; public hearing for rate increase; failure to make premium adjustments.

Sec. 3855. (1) Each insurer that issues medicare supplement policies for delivery in this state shall file annually with the commissioner, on a form and in the manner prescribed by the commissioner, its rates, rating schedule, and supporting documentation including all claims experience of the insurer for medicare supplement coverage. The filings and schedules shall demonstrate that the actual and expected losses in relation to premiums are in compliance with the applicable loss ratio standards of this state. The supporting documentation shall also be in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed excluding active life reserves. An expected third-year loss ratio that is greater than or equal to the applicable percentage under section 3851 shall be demonstrated for policies or certificates in force less than 3 years.

(2) An insurer shall make such premium adjustments as are necessary to produce an expected loss ratio under the medicare supplement policy as will conform with minimum loss ratio standards for medicare supplement policies and certificates and that are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the insurer for such medicare supplement insurance policies. A premium adjustment that would modify the loss ratio experience under the policy shall not be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(3) The commissioner may conduct a public hearing to gather information concerning a request by a medicare supplement insurer for an increase in a rate for a medicare supplement policy form or certificate form issued before or after the effective date of this chapter if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance shall be made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner considered appropriate by the commissioner.

(4) If a medicare supplement insurer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds, or premium credits considered necessary to achieve the loss ratio required by this section.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3857 Duties of insurer; certification of compliance with subsection (1)(a).

Sec. 3857. (1) An insurer shall do all of the following:

(a) Accept a notice from a medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and make a payment determination on the basis of the information contained in that notice.

(b) Notify the participating physician or supplier and the beneficiary of the payment determination.

(c) Pay the participating physician or supplier directly.

(d) Furnish, at the time of enrollment, each enrollee with a card listing the policy name, number, and a

central mailing address to which notices from a medicare carrier may be sent.

(e) Pay user fees for claim notices that are transmitted electronically or otherwise.

(f) Provide to the secretary of health and human services, at least annually, a central mailing address to which all claims may be sent by medicare carriers.

(2) Compliance with the requirements set forth in subsection (1)(a) shall be certified on the medicare supplement insurance experience reporting form.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3859 Prohibited conduct; violation as misdemeanor; penalty.

Sec. 3859. (1) A person shall not knowingly sell a health insurance policy or certificate to an individual entitled to benefits under part A or enrolled under part B of medicare with knowledge that the policy or certificate substantially duplicates health benefits to which the individual is otherwise entitled, other than benefits to which the individual is entitled under a requirement of state or federal law other than medicare. A person who violates this subsection is guilty of a misdemeanor punishable by imprisonment for not more than 2 years, or a fine of not more than $10,000.00, or both. The court may order a person convicted under this subsection to pay restitution to individuals for expenses incurred as a result of violation of this subsection. For purposes of this subsection, benefits that are payable to or on behalf of an individual without regard to other health benefit coverage of the individual shall not be considered as duplicative. The selling of a group certificate or contract of the trustees of a fund established by 1 or more employers, labor organizations, or both, for employees, former employees, or both, or for members or former members, or both, of labor organizations, shall not be considered to be a violation of this subsection.

(2) A person shall not falsely assume or pretend to be acting or misrepresent in any way that he or she is acting under the authority of or in association with medicare or any state or federal agency, for the purpose of selling or attempting to sell insurance or, in such a pretended character, demand or obtain money, paper, documents, or any thing of value. A person who violates this subsection is guilty of a misdemeanor punishable by imprisonment for not more than 2 years, or a fine of not more than $10,000.00, or both.

(3) A person shall not solicit, offer for sale, or deliver a medicare supplement policy in this state, unless the policy has been approved by the commissioner. A person who violates this subsection is guilty of a misdemeanor punishable by imprisonment for not more than 1 year, or a fine of not more than $5,000.00, or both.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218

500.3861 Probable cause of violation; notice of hearing; opportunity to confer and discuss; hearing; applicability of MCL 500.2038 to 500.2040; violation; penalty.

Sec. 3861. (1) If the commissioner has probable cause to believe that an insurer or agent has violated or is violating this chapter and that a hearing by the commissioner would be in the public interest, the commissioner shall give notice in writing to the person involved pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws, setting forth the general nature of the complaint against him or her, and the proceedings contemplated. Before the issuance of a notice of hearing, the commissioner shall give the person an opportunity to confer and discuss the possible complaint and proceedings in person with the commissioner or his or her representative, and the matter may be disposed of summarily upon agreement of the parties.

(2) The provisions of section 2030 shall apply with respect to a hearing held pursuant to subsection (1), except that the use of an independent hearing officer shall not be allowed.

(3) If, after opportunity for a hearing held pursuant to Act No. 306 of the Public Acts of 1969, the commissioner determines that the insurer or agent has violated this chapter, the provisions of sections 2038 to 2040 shall apply. Each medicare supplement policy issued or delivered in violation of any of the provisions contained in this chapter shall constitute a separate violation for purposes of assessing a civil fine.

(4) In addition to any other applicable penalties for violations of this act, the commissioner may require insurers violating this chapter to cease marketing any medicare supplement policy or certificate in this state that is related directly or indirectly to a violation or may require the insurer to take such actions as are necessary to comply with this chapter.

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992.

Popular name: Act 218