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Introduced by Rep. Varga

Reps. Anthony, Bandstra, Bankes, Barns, Bartnik, Bennane, Bennett, Bobier, Brackenridge, Perry Bullard, Willis Bullard, Clack, Clarke, Dalman, DeMars, Dobb, Dobronski, Dolan, Dresch, Gagliardi, Gernaat, Gilmer, Goss, Gubow, Harder, Harrison, Jacobetti, Jaye, Johnson, Jonker, Keith, Kilpatrick, Kosteva, Leland, London, McBryde, Murphy, Olshove, Oxender, Palamara, Pitoniak, Profit, Saunders, Scott, Shugars, Stallworth, Wallace, Weeks, Yokich and Joe Young, Jr. named co-sponsors

ENROLLED HOUSE BILL No. 5501

AN ACT to amend sections 1204b, 1204c, and 8199a of Act No. 218 of the Public Acts of 1956, entitled as amended "An act to revise, consolidate, and classify the laws relating to the insurance and surety business; to regulate the incorporation or formation of domestic insurance and surety companies and associations and the admission of foreign and alien companies and associations; to provide their rights, powers, and immunities and to prescribe the conditions on which companies and associations organized, existing, or authorized under this act may exercise their powers; to provide the rights, powers, and immunities and to prescribe the conditions on which other persons, firms, corporations, associations, risk retention groups, and purchasing groups engaged in an insurance or surety business may exercise their powers; to provide for the imposition of a privilege fee on domestic insurance companies and associations and the state accident fund; to provide for the imposition of a tax on the business of foreign and alien companies and associations; to provide for the imposition of a tax on risk retention groups and purchasing groups; to provide for the imposition of a tax on the business of surplus line agents; to modify tort liability arising out of certain accidents; to provide for limited actions with respect to that modified tort liability and to prescribe certain procedures for maintaining those actions; to require security for losses arising out of certain accidents; to provide for the continued availability and affordability of automobile insurance and homeowners insurance in this state and to facilitate the purchase of that insurance by all residents of this state at fair and reasonable rates; to provide for certain reporting with respect to insurance and with respect to certain claims against uninsured or self-insured persons; to prescribe duties for certain state departments and officers with respect to that reporting; to provide for certain assessments; to establish and continue certain state insurance funds; to modify and clarify the status, rights, powers, duties, and operations of the nonprofit malpractice insurance fund; to provide for the departmental supervision and regulation of the insurance and surety business within this state; to provide for the conservation, rehabilitation, or liquidation of unsound or insolvent insurers; to provide for the protection of policyholders, claimants, and creditors of unsound or insolvent insurers; to provide for associations of insurers to protect policyholders and claimants in the event of insurer insolvencies; to prescribe educational requirements for insurance agents and solicitors; to provide for the regulation of multiple employer welfare arrangements; to create an automobile theft prevention authority to reduce the number of automobile thefts in this state; to prescribe the powers and duties of the automobile theft

prevention authority; to provide certain powers and duties upon certain officials, departments, and authorities of this state; to repeal certain acts and parts of acts; to repeal certain acts and parts of acts on specific dates; to repeal certain parts of this act on specific dates; and to provide penalties for the violation of this act," section 1204b as amended and section 1204c as added by Act No. 1 of the Public Acts of 1992 and section 8199a as added by Act No. 1 of the Public Acts of 1990, being sections 500.1204b, 500.1204c, and 500.8199a of the Michigan Compiled Laws; to add section 2005a and chapters 38 and 39; and to repeal certain parts of the act.

The People of the State of Michigan enact:

Section 1. Sections 1204b, 1204c, and 8199a of Act No. 218 of the Public Acts of 1956, section 1204b as amended and section 1204c as added by Act No. 1 of the Public Acts of 1992 and section 8199a as added by Act No. 1 of the Public Acts of 1990, being sections 500.1204b, 500.1204c, and 500.8199a of the Michigan Compiled Laws, are amended and section 2005a and chapters 38 and 39 are added to read as follows:

Sec. 1204b. (1) An insurance agent education advisory council is created within the department of commerce. The commissioner shall appoint the members of the council. The council shall be composed of the following:

(a) Two representatives of the Michigan association of life underwriters.

(b) Two representatives of the professional independent insurance agents of Michigan.

(c) Three insurer representatives.

(d) At least 1 licensed property and casualty insurance agent.

(e) At least 1 licensed life insurance agent.

(f) One representative of the insurance education field.

(g) One representative of the general public.

(h) The commissioner as an ex officio member.

(2) Initially, 3 members shall be appointed for a term of 1 year, 3 members for a term of 2 years, and the remaining members for a term of 3 years. Thereafter, members of the council shall serve for a term of 3 years and for not more than 2 consecutive terms. The council shall meet on at least a semiannual basis. Members shall serve without compensation but shall be reimbursed for their actual and necessary expenses.

(3) The council shall do all of the following:

(a) Review and make recommendations to the commissioner with respect to course materials, curriculum, and the credentials of the instructors of each program of study registered with the commissioner pursuant to section 1204a.

(b) Review continuing education programs of study under section 1204c(4) and make recommendations to the commissioner on whether those programs meet the requirements in section 1204c(5).

(c) Make recommendations to the commissioner with respect to educational requirements of insurance agents.

(4) A member of the council or designee of the commissioner shall be permitted access to any classroom while instruction is in progress to monitor the classroom instruction.

Sec. 1204c. (1) As used in this section:

(a) "Agent" means a life-health agent or property-casualty agent licensed under this chapter.

(b) "Hour" means a period of time of not less than 50 minutes.

(c) "Life-health agent" means a resident or nonresident agent licensed for life, limited life, credit life, mortgage redemption, accident and health, or any combination thereof.

(d) "Property-casualty agent" means a resident or nonresident agent or solicitor licensed for automobile, fire, multiple lines, any limited or minor property and casualty line, or any combination thereof.

(2) Unless the agent has renewed his or her license pursuant to subsection (4), an agent's hours of study accrued under this section shall be reviewed for license continuance as follows:

(a) If the agent's license number ends in "1" as follows:

(*i*) If the agent's last name starts with A to L, on January 1, 1995 and on January 1 every 2 years thereafter.

(*ii*) If the agent's last name starts with M to Z, on January 1, 1996 and on January 1 every 2 years thereafter.

(b) If the agent's license number ends in "2" as follows:

(*i*) If the agent's last name starts with A to L, on February 1, 1995 and on February 1 every 2 years thereafter.

(*ii*) If the agent's last name starts with M to Z, on February 1, 1996 and on February 1 every 2 years thereafter.

(c) If the agent's license number ends in "3" as follows:

(*i*) If the agent's last name starts with A to L, on March 1, 1995 and on March 1 every 2 years thereafter.

(*ii*) If the agent's last name starts with M to Z, on March 1, 1996 and on March 1 every 2 years thereafter.

(d) If the agent's license number ends in "4" as follows:

(*i*) If the agent's last name starts with A to L, on June 1, 1995 and on June 1 every 2 years thereafter.

(*ii*) If the agent's last name starts with M to Z, on June 1, 1996 and on June 1 every 2 years thereafter.

(e) If the agent's license number ends in "5" as follows:

(*i*) If the agent's last name starts with A to L, on July 1, 1995 and on July 1 every 2 years thereafter.

(*ii*) If the agent's last name starts with M to Z, on July 1, 1996 and on July 1 every 2 years thereafter.

(f) If the agent's license number ends in "6" as follows:

(*i*) If the agent's last name starts with A to L, on August 1, 1995 and on August 1 every 2 years thereafter.

(*ii*) If the agent's last name starts with M to Z, on August 1, 1996 and on August 1 every 2 years thereafter.

(g) If the agent's license number ends in "7" as follows:

(*i*) If the agent's last name starts with A to L, on September 1, 1995 and on September 1 every 2 years thereafter.

(*ii*) If the agent's last name starts with M to Z, on September 1, 1996 and on September 1 every 2 years thereafter.

(h) If the agent's license number ends in "8" as follows:

(*i*) If the agent's last name starts with A to L, on October 1, 1995 and on October 1 every 2 years thereafter.

(*ii*) If the agent's last name starts with M to Z, on October 1, 1996 and on October 1 every 2 years thereafter.

(i) If the agent's license number ends in "9" as follows:

(*i*) If the agent's last name starts with A to L, on November 1, 1995 and on November 1 every 2 years thereafter.

(*ii*) If the agent's last name starts with M to Z, on November 1, 1996 and on November 1 every 2 years thereafter.

(j) If the agent's license number ends in "0" as follows:

(*i*) If the agent's last name starts with A to L, on December 1, 1995 and on December 1 every 2 years thereafter.

(*ii*) If the agent's last name starts with M to Z, on December 1, 1996 and on December 1 every 2 years thereafter.

(3) If an agent's hours of study would be reviewed according to the schedule under subsection (2) within 23 months after issuance of the initial license, the hours shall not be reviewed on the first scheduled date following the issuance of the initial license and shall be reviewed on the next scheduled review date following the first review date according to the schedule under subsection (2), unless the agent has renewed his or her license pursuant to subsection (4).

(4) Except as provided in subsections (11) to (14), before the review date of each applicable 2-year period provided for under subsection (2) or (3), an agent wishing to renew his or her license shall renew his or her license by attending or instructing not less than 30 hours of continuing education classes approved by the commissioner or 30 hours of home study if evidenced by successful completion of course work approved by the commissioner. Of the 30 hours of continuing education required, a life-health agent shall attend or instruct not less than 15 hours in a program of study approved for life-health agents and a property-casualty agent shall attend or instruct not less than 15 hours in a program of study approved for property-casualty agents.

(5) After reviewing recommendations made by the council under section 1204b, the commissioner shall approve a program of study if the commissioner determines that the program increases knowledge of insurance and related subjects as follows:

(a) For a life-health agent program of study, the program offers instruction in 1 or more of the following:

(*i*) The fundamental considerations and major principles of life insurance.

(*ii*) The fundamental considerations and major principles of health insurance.

(*iii*) Estate planning and taxation as related to insurance.

(*iv*) Industry and legal standards concerning ethics in insurance.

(*v*) Legal, legislative, and regulatory matters concerning insurance, the insurance code, and the insurance industry.

(*vi*) Principal provisions used in life insurance contracts, health insurance contracts, or annuity contracts and differences in types of coverages.

(*vii*) Accounting and actuarial considerations in insurance.

(b) For a property-casualty agent program of study, the program offers instructions in 1 or more of the following:

(*i*) The fundamental considerations and major principles of property insurance.

(*ii*) The fundamental considerations and major principles of casualty insurance.

(*iii*) Basic principles of risk management.

(*iv*) Industry and legal standards concerning ethics in insurance.

(*v*) Legal, legislative, and regulatory matters concerning insurance, the insurance code, and the insurance industry.

(*vi*) Principal provisions used in casualty insurance contracts, no-fault insurance contracts, or property insurance contracts and differences in types of coverages.

(*vii*) Accounting and actuarial considerations in insurance.

(6) A provider of a program of study for agents applying for approval or reapproval from the commissioner under this section shall file, on a form provided by the commissioner, a description of the course of study including a description of the subject matter and course materials, hours of instruction, location of classroom, qualifications of instructors, and maximum student-instructor ratio and shall pay a nonrefundable $25.00 filing fee. Any material change in a program of study shall require reapproval by the commissioner. If the information in an application for approval or reapproval is insufficient for the commissioner to determine whether the program of study meets the requirements under subsection (5), the commissioner shall give written notice to the provider, within 15 days after the provider's filing of the application for approval or reapproval, of the additional information needed by the commissioner. An application for approval or reapproval shall be considered approved unless disapproved by the commissioner within 90 days after the application for approval or reapproval is filed, or within 90 days after the receipt of additional information if the information was requested by the commissioner, whichever is later.

(7) A provider of a program of study approved by the commissioner under this section shall pay a provider authorization fee of $500.00 for the first year the provider's program of study was approved under this section and a $100.00 provider renewal fee for each year thereafter that the provider offers the approved program of study.

(8) A person dissatisfied with an approved program of study may petition the commissioner for a hearing on the program or the commissioner on his or her own initiative may request a hearing on a program of study. If the commissioner finds the petition to have been submitted in good faith, that the petition if true shows the program of study does not satisfy the criteria in subsection (5), or that the petition otherwise justifies holding a hearing, the commissioner shall hold a hearing pursuant to chapter 4 of the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.271 to 24.287 of the Michigan Compiled Laws, within 30 days after receipt of the petition and upon not less than 10 days' written notice to the petitioner and the provider of the program of study. If the commissioner requests a hearing on a program of study on his or her own initiative, the commissioner shall hold a hearing pursuant to chapter 4 of Act No. 306 of the Public Acts of 1969, upon not less than 10 days' written notice to the provider of the program of study.

(9) If after a hearing under subsection (8) the commissioner finds that the program of study does not satisfy the requirements under subsection (5), the commissioner shall state, in a written order mailed first class to the petitioner and provider of the program of study, his or her findings and the date upon which the commissioner will revoke approval of the program of study which date shall be within a reasonable time of the issuance of the order.

(10) A certificate of attendance or instruction of an approved program of study or a certificate of successful completion of course work shall be filed as directed by the commissioner on a form prescribed by the commissioner and shall indicate the name and number of the course of study, the number of hours, dates of completion, and the name and number of schools attended or taught by the agent or the evidence of successful completion of course work. A representative of the approved program of study shall file the form and a fee of $1.00 per hour for course credit for each agent license renewal as directed by the commissioner within 30 days after the agent completes the program. A copy of the form shall also be mailed first class to the agent who attended, taught, or successfully completed the program of study. The commissioner may enter into contracts to provide for the administrative functions of this subsection.

(11) The commissioner may waive the continuing education requirements of this section for an agent if the commissioner determines that enforcement of the requirements would cause a severe hardship.

(12) The commissioner may enter into reciprocal continuing education agreements with insurance commissioners from other states. A person who is licensed pursuant to section 1204(5) shall not be subject to the continuing education requirements under this section if there is a reciprocal insurance continuing education agreement with the insurance commissioner of the state of the applicant's principal residence and there are continuing education requirements in the state of the applicant's residence.

(13) If an agent has not met his or her continuing education requirements by the expiration date of his or her license, the agent shall have a 90-day grace period in which to meet the continuing education requirements of this section. During the 90-day grace period the agent shall not solicit or sell new policies of insurance, bind coverage, or otherwise act as an agent except that the agent may continue to service policies previously sold and may receive commissions on policies previously sold. If the agent has not met his or her continuing education requirements by the expiration of the 90-day grace period, the agent's license shall be canceled. An agent whose license has been canceled under this section may reapply for license to act as an agent under section 1204, except that the program of study requirements under section 1204 shall not be waived.

(14) An agent who has sold his or her insurance business and who has not met the continuing education requirements of this section shall not solicit or sell new policies of insurance, bind coverage, or otherwise act as an agent except that the agent may continue to service policies previously sold and may receive commissions on policies previously sold as well as receive partial commissions on policies of insurance sold by a purchasing agent. An agent who is in the process of selling his or her insurance business and who has not met the continuing education requirements of this section shall not solicit or sell new policies of insurance, bind coverage, or otherwise act as an agent except that the agent may continue to service policies previously sold and may receive commissions on policies previously sold as well as receive partial commissions on policies of insurance sold by a purchasing agent, for a period not to exceed 12 months after the selling agent's license review date under subsection (2). An agent whose license has been canceled and who wishes to resume soliciting or selling new policies of insurance, bind coverage, or otherwise act as an agent and who has not met the continuing education requirements within the immediately preceding 2-year period may reapply for license to act as an agent under section 1204, except that the program of study requirements under section 1204 shall not be waived.

Sec. 2005a. An unfair method of competition and an unfair or deceptive act or practice in the business of insurance includes all of the following:

(a) Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies, certificates, or contracts of insurers, health care corporations, or health maintenance organizations for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy, certificate, or contract or to take out a policy, certificate, or contract with another insurer, health care corporation, or health maintenance organization.

(b) Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, or threat, whether explicit or implied, or undue pressure.

(c) Making use directly or indirectly of any method of marketing that fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

CHAPTER 38

MEDICARE SUPPLEMENT POLICIES AND CERTIFICATES

Sec. 3801. As used in this chapter:

(a) "Applicant" means:

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

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

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

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

(d) "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.

(e) "Medicaid" means title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396f, and 1396i to 1396u.

(f) "Medicare" means title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395c to 1395i, 1395i-2 to 1395i-4, 1395j to 1395t, 1395u to 1395w-2, 1395w-4 to 1395zz, and 1395bbb to 1395ccc.

(g) "Medicare supplement buyer's guide" means the document entitled, "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 commissioner.

(h) "Medicare supplement policy" means an individual or group policy or certificate of insurance 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 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.

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

Sec. 3803. (1) Except as provided in subsection (2), this chapter applies to a medicare supplement policy delivered, issued for delivery, or renewed in this state on or after the effective date of this chapter.

(2) Sections 3809, 3811, and 3819(1) do not apply to a medicare supplement policy issued before the effective date of this chapter.

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 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, Act No. 368 of the Public Acts of 1978, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws.

(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.

Sec. 3807. 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 61st day through the 90th 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 the medicare part A eligible expenses for hospitalization paid at the diagnostic related group day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days.

(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 of medicare eligible expenses under part B regardless of hospital confinement, subject to the medicare part B deductible.

Sec. 3808. Every insurer issuing a medicare supplement insurance policy in this state shall make available a medicare supplement insurance policy that includes the benefits provided in section 3811(5)(c).

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.

(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.

(h) Medically necessary emergency care in a foreign country: coverage to the extent not covered by medicare for 80% of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250.00, and a lifetime maximum benefit of $50,000.00. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

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

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

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

(A) Fecal occult blood test and digital rectal examination.

(B) Mammogram.

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

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

(E) Serum cholesterol screening every 5 years.

(F) Thyroid function test.

(G) Diabetes screening.

(H) Influenza vaccine administered at any appropriate time during the year and tetanus and diphtheria booster every 10 years.

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

(j) At-home recovery benefit: coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery. At-home recovery services provided shall be primarily services that assist in activities of daily living. The 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 new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. These 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.

(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.

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 J 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 J 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).

(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).

(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).

(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).

Sec. 3813. An insurer that issues a policy that provides disability coverage to a person eligible for medicare by reason of age shall provide the prospective policyholder with a medicare supplement buyer's guide, which shall be furnished at the time of application, and acknowledgment of receipt of the buyer's guide shall be obtained by the insurer. However for direct response solicitation policies, the guide shall be furnished with the policy and acknowledgment of receipt need not be obtained by the insurer. 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.

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 and, except for direct response solicitation policies, shall obtain an acknowledgment of receipt of the outline of coverage from the applicant. The outline of coverage provided to applicants pursuant to this section shall 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) An outline of coverage under subsection (1) shall be in the language and format prescribed in this section and in not less than 12-point type. The A through J letter designation of the plan shall be shown on the cover page and the plans offered by the insurer shall be prominently identified. Premium information shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and method of payment mode shall be stated for all plans that are offered to the applicant. All possible premiums for the applicant shall be illustrated. The following items shall be included in the outline of coverage in the order prescribed below and in substantially the following form, as approved by the commissioner:

(Insurer Name)
Medicare Supplement Coverage
Outline of Medicare Supplement Coverage-Cover Page:
Benefit Plan(s) _____ [insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only 10 standard plans. This chart shows the benefits included in each plan. Every insurer shall make available Plan "A". Some plans may not be available in your state.
Basic Benefits: Included in All Plans.
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses).
Blood: First three pints of blood each year.

	A	B	C	D	E	F	G	H	I	J
Basic Benefits	X	X	X	X	X	X	X	X	X	X
Skilled Nursing Co-Insurance			X	X	X	X	X	X	X	X
Part A Deductible		X	X	X	X	X	X	X	X	X
Part B Deductible			X			X				X
Part B Excess						X 100%	X 80%		X 100%	X 100%
Foreign Travel Emergency			X	X	X	X	X	X	X	X
At-Home Recovery				X			X		X	X
Drugs								X $1,250 Limit	X $1,250 Limit	X $3,000 Limit
Preventive Care										X

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.

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 pursuant to 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 commissioner. 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 $628	$0	$628 (Part A Deductible)
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 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 $78.50 a day	$0	Up to $78.50 a day
101st day and after	$0	$0	All costs

BLOOD First 3 pints Additional amounts	 $0 100%	 3 pints $0	 $0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN A

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

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $100 of Medicare Approved Amounts*	$0	$0	$100 (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 $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Blood 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 $100 of Medicare Approved Amounts*	$0	$0	$100 (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 $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $314 a day	$314 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 $78.50 a day	$0	Up to $78.50 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN B

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

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $100 of Medicare Approved Amounts*	$0	$0	$100 (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 $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—			
Blood 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 $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$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	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $314 a day	$314 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 $78.50 a day	Up to $78.50 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN C

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

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
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 $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—			
Blood 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 $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
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 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 $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $314 a day	$314 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 $78.50 a day	Up to $78.50 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN D

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

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $100 of Medicare Approved Amounts*	$0	$0	$100 (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 $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Blood tests for diagnostic services	100%	$0	$0

HOME HEALTH CARE			
Medicare Approved Services			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—			
Not covered by Medicare			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
—Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

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 E

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 $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after —While using 60 lifetime reserve days	All but $314 a day	$314 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 $78.50 a day	Up to $78.50 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN E

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

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $100 of Medicare Approved Amounts*	$0	$0	$100 (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 $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—			
Blood 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 $100 of Medicare Approved Amounts*	$0	$0	$100 (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
PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All Costs

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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after —While using 60 lifetime reserve days	All but $314 a day	$314 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 $78.50 a day	Up to $78.50 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN F

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

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
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 $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Blood 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 $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $100 (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

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 $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after —While using 60 lifetime reserve days	All but $314 a day	$314 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 $78.50 a day	Up to $78.50 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN G

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

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Blood 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 $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES— Not covered by Medicare Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
—Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

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 H

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 $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $314 a day	$314 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 $78.50 a day	Up to $78.50 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN H

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

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $100 of Medicare Approved Amounts*	$0	$0	$100 (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 $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—			
Blood 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 $100 of Medicare Approved Amounts*	$0	$0	$100 (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
BASIC OUTPATIENT PRESCRIPTION DRUGS— Not covered by Medicare			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%—$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All Costs

PLAN I

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 $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after —While using 60 lifetime reserve days	All but $314 a day	$314 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 $78.50 a day	Up to $78.50 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN I

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

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
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 $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— Blood 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 $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $100 (Part B Deductible) $0
AT-HOME RECOVERY SERVICES— Not covered by Medicare Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan —Benefit for each visit —Number of visits covered (must be received within 8 weeks of last Medicare Approved visit) —Calendar year maximum	 $0 $0 $0	 Actual Charges to $40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week $1,600	 Balance

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
BASIC OUTPATIENT PRESCRIPTION DRUGS— Not covered by Medicare First $250 each calendar year Next $2,500 each calendar year Over $2,500 each calendar year	 $0 $0 $0	 $0 50%—$1,250 calendar year maximum benefit $0	 $250 50% All Costs

PLAN J

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 $628	$628 (Part A Deductible)	$0
61st thru 90th day	All but $157 a day	$157 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $314 a day	$314 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 $78.50 a day	Up to $78.50 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN J

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

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
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 $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—			
Blood 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 $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts AT-HOME RECOVERY SERVICES— Not covered by Medicare Home care certified by your doctor, for personal care beginning during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan —Benefit for each visit —Number of visits covered (must be received within 8 weeks of last Medicare Approved visit) —Calendar year maximum	100% $0 80% $0 $0	$0 $100 (Part B Deductible) 20% Actual Charges to $40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week $1,600	$0 $0 $0 Balance

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
EXTENDED OUTPATIENT PRESCRIPTION DRUGS— Not covered by Medicare First $250 each calendar year Next $6,000 each calendar year Over $6,000 each calendar year	$0 $0 $0	$0 50%—$3,000 calendar year maximum benefit $0	$250 50% All Costs

PREVENTIVE MEDICAL CARE BENEFIT—			
Not covered by Medicare			
Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All costs

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, chapter 531, 49 Stat. 620, 42 U.S.C. 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.

(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 outpatient prescription drugs, 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 prescription drugs, 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.

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 amount and copayment percentage factors. 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.

(f) 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. All of the following apply to the reinstitution of a medicare supplement policy under this subsection:

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

(*ii*) Reinstituted coverage shall be substantially equivalent to coverage in effect before the date of the suspension.

(*iii*) 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.

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.

Sec. 3823. 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.

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.

Sec. 3827. (1) A medicare supplement insurance policy or certificate shall 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 shall include the following statements and questions designed to inform and elicit information as to whether, as of the date of the application, the applicant has another medicare supplement or other health insurance policy or certificate in force or whether a medicare supplement policy or certificate is intended to replace any disability or other health policy or certificate presently in force:

[STATEMENTS]

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

(2) If you are 65 or older, you may be eligible for benefits under medicaid and may not need a medicare supplement policy.

(3) 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 of becoming eligible for medicaid. If you are no longer entitled to medicaid, your policy will be reinstituted if requested within 90 days of losing medicaid eligibility.

(4) Counseling services may be available in your state to provide advice concerning your purchase of medicare supplement insurance and concerning medicaid.

[QUESTIONS]

These questions should be answered to the best of your knowledge.

(1) Do you have another medicare supplement insurance policy, certificate, or contract in force (including a health care corporation certificate or health maintenance organization contract)? If so, with which company?

(2) Do you have any other health insurance policies, certificates, or contracts that provide benefits that this medicare supplement policy would duplicate? If so, with which company? What kind of policy, certificate, or contract?

(3) If the answer to question 1 or 2 is yes, do you intend to replace these disability or health policies, certificates, or contracts with this policy or certificate?

(4) Are you covered by medicaid?

(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, a copy of the application or supplement form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy or certificate.

(5) Upon 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 prior to 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, except where coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall 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 shall be provided in substantially the following form and in not less than 10-point type:

"NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT COVERAGE

(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 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 coverage, 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

_____ Other. (Please specify)

1. Health conditions which you may presently have (preexisting 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 preexisting 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)"

Sec. 3829. 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 first enrolled for benefits under medicare part B. Each medicare supplement policy currently available from an insurer shall be made available to all applicants who qualify under this section without regard to age.

Sec. 3831. (1) Each insurer offering individual or group expense incurred hospital, medical, or surgical policies or certificates in this state shall provide without restriction, to any person who requests coverage from an insurer and has been insured with an insurer subject to this section, if the person would no longer be insured because he or she has become eligible for medicare or if the person loses coverage under a group policy after becoming eligible for medicare, a right of continuation or conversion to their choice of the basic core benefits as described in section 3807 or a type C medicare supplemental package as described in section 3811(5)(c) that is guaranteed renewable or noncancellable. 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 shall not be entitled to coverage under this subsection until the day following the date of discharge. However, if the hospitalized person was insured by the insurer immediately prior to becoming eligible for medicare or immediately prior to losing coverage under a group policy after becoming eligible for medicare, the person shall be eligible for immediate coverage from the previous insurer under this subsection. A person shall not be entitled to a medicare supplemental policy under this subsection 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 this subsection must either request coverage within 90 days before or 90 days after the month he or she becomes eligible for medicare or 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.

(2) Except as provided in section 3833, a person not insured under an individual or 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), shall be 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).

(3) Each insurer offering individual expense incurred hospital, medical, or surgical policies in this state shall give to each person who is insured with the insurer at the time he or she becomes eligible for medicare, and to each applicant of the insurer who is eligible for medicare, written notice of the availability of coverage under this section. 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.

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.

Sec. 3835. (1) Each insurer marketing 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 disability or other health coverage and the types and amounts of 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) A medical supplement policy shall 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."

Sec. 3837. (1) On or before March 1 of each year, every insurer providing medicare supplement insurance coverage in this state shall report to the commissioner the following information for every individual resident of this state for which the insurer has in force more than 1 medicare supplement insurance policy or certificate:

(a) Policy and certificate number.

(b) Date of issuance.

(2) The items in subsection (1) shall be grouped by individual policyholder.

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.

(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 (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.

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.

Sec. 3843. (1) Any policy or certificate of disability insurance issued for delivery in this state to persons eligible for medicare by reason of age shall notify insureds under the policy or certificate that the policy is not a medicare supplement policy. The notice shall 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 shall be in not less than 12-point type, and shall 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.

Sec. 3847. Each insurer providing medicare supplement insurance coverage in this state shall file with the commissioner for review a copy of any written, radio, or television advertisement for medicare supplement insurance intended for use in this state at least 45 days before the date the insurer desires to use the advertising. The filing shall include a sample or photocopy of all applicable medicare supplement policies and related forms and the approval status of the policies and forms.

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 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.

(3) Except as provided in subsection (4), 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.

(4) 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.

(5) Except as provided in subsection (6), 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.

(6) 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.

(7) An insurer that discontinues the availability of a medicare supplement policy form or certificate form pursuant to subsection (6) 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.

(8) 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.

(9) 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.

(10) 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, chapter 531, 49 Stat. 620, 42 U.S.C. 1395u and 1395ss, and shall certify that compliance on the medicare supplement insurance experience reporting form.

(11) 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.

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.

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.

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.

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.

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.

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.

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.

CHAPTER 39. LONG-TERM CARE INSURANCE

Sec. 3901. As used in this chapter:

(a) "Acute condition" means that the individual is medically unstable, requiring frequent monitoring by medical professionals in order to maintain his or her health status.

(b) "Applicant" means:

(*i*) For an individual long-term care insurance policy, the person who seeks to contract for long-term care benefits.

(*ii*) For a group long-term care insurance certificate, the proposed certificate holder.

(c) "Group long-term care insurance" means a long-term care insurance certificate that is delivered or issued for delivery in this state and issued to any of the following:

(*i*) One or more employers or labor organizations, or to a trust or the trustees of a fund established by 1 or more employers or labor organizations for employees or former employees or members or former members of the labor organization.

(*ii*) A professional, trade, or occupational association for its members or former or retired members if the association is composed of individuals who were all actively engaged in the same profession, trade, or occupation and the association has been maintained in good faith for purposes other than obtaining insurance unless waived by the commissioner.

(*iii*) Subject to section 3903(2), an association or to a trust or to the trustees of a fund established, created, or maintained for the benefit of members of 1 or more associations.

(*iv*) A group other than that described in subparagraphs (*i*), (*ii*), or (*iii*) if the commissioner determines all of the following:

(A) The issuance of the group certificate is not contrary to the best interests of the public.

(B) The issuance of the group certificate would result in economies of acquisition or administration.

(C) The benefits are reasonable in relation to the premiums charged.

(d) "Guaranteed renewable" means the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and the insurer does not have a unilateral right to make any change in any provision of the policy or rider while the insurance is in force and cannot decline to renew, except that rates may be revised by the insurer on a class basis.

(e) "Home care services" means 1 or more of the following medically prescribed services or assessment team recommended services for the long-term care and treatment of an insured that are to be provided in a noninstitutional setting according to a written diagnosis and plan of care or individual assessment and plan of care:

(*i*) Nursing services under the direction of a registered nurse, including the service of a home health aide.

(*ii*) Physical therapy.

(*iii*) Speech therapy.

(*iv*) Respiratory therapy.

(*v*) Occupational therapy.

(*vi*) Nutritional services provided by a registered dietitian.

(*vii*) Personal care services, homemaker services, adult day care, and similar nonmedical services.

(*viii*) Medical social services.

(*ix*) Other similar medical services and health-related support services.

(f) "Home health or care agency" means a person certified by medicare whose business is to provide to individuals in their places of residence other than in a hospital, nursing home, or county medical care facility, 1 or more of the following services: nursing services, therapeutic services, social work services, homemaker services, home health aide services, or other related services.

(g) "Intermediate care facility" means a facility, or distinct part of a facility, certified by the department of public health to provide intermediate care, custodial care, or basic care that is less than skilled nursing care but more than room and board.

(h) "Long-term care insurance" means an individual or group insurance policy, certificate, or rider advertised, marketed, offered, or designed to provide coverage for at least 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis for 1 or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, personal, or custodial care services provided in a setting other than an acute care unit of a hospital. Long-term care insurance includes individual or group annuities and life insurance policies or riders that provide directly or supplement long-term care insurance. Long-term care insurance does not include a life insurance policy that accelerates the death benefit specifically for 1 or more of the qualifying events of terminal illness or medical conditions requiring extraordinary medical intervention or permanent institutional confinement and that provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Long-term care insurance does not include an insurance policy offered primarily to provide coverage for rehabilitative and convalescent care and is not offered, advertised, or marketed as a long-term care policy, or offered primarily to provide basic medicare supplemental coverage, hospital confinement indemnity coverage, basic hospital expense coverage, basic medical-surgical expense coverage, major medical expense coverage, disability income protection coverage, catastrophic coverage, comprehensive coverage, accident only coverage, specific disease or specified accident coverage, or limited benefit health coverage.

(i) "Medicare" means title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395c to 1395i, 1395i-2 to 1395i-4, 1395j to 1395t, 1395u to 1395w-2, 1395w-4 to 1395zz, and 1395bbb to 1395ccc.

(j) "Preexisting condition" means a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within the 6 months immediately before the effective date of coverage of an insured person.

(k) "Policy" means an insurance policy or certificate, rider, or endorsement delivered or issued for delivery in this state by an insurer.

(*l*) "Skilled nursing facility" means a facility, or a distinct part of a facility, certified by the department of public health to provide skilled nursing care.

Sec. 3903. (1) Group long-term care insurance coverage shall not be offered to a resident of this state under a group certificate issued in another state to a group described in section 3901(c)(*iv*), unless this state or another state which the commissioner determines has and enforces statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that those requirements have been met.

(2) Before advertising, marketing, or offering a group long-term care insurance certificate within this state to a group described in section 3901(c)(*iii*), the group or the insurer shall file evidence with the commissioner that the group meets all of the following requirements:

(a) Consists of at least 100 members.

(b) Has been in active existence for at least 1 year.

(c) Holds regular meetings at least annually.

(d) Except for credit unions, the group collects dues or solicits contributions from members.

(e) The members have voting privileges and representation on the governing board and committees.

(f) Has been organized and maintained in good faith for purposes other than obtaining insurance unless the commissioner waives this requirement.

(3) Thirty days after making the filing under this section, the group described in section 3901(c)(*iii*) shall be considered to satisfy subsection (2) organizational requirements, unless the commissioner makes a finding that the group does not satisfy those organizational requirements.

Sec. 3905. (1) Long-term care coverage shall meet all of the following requirements:

(a) Shall include coverage for intermediate/basic care, which shall not be significantly less than the coverage provided for skilled nursing care.

(b) Shall not limit or exclude coverage by type of illness, type of provider, territorial limitations, treatment, medical condition, or accident other than a motor vehicle accident, except as follows:

(*i*) Preexisting conditions.

(*ii*) Mental or nervous disorders; however, this shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder and shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease or related disorders.

(*iii*) Alcoholism or drug addiction.

(*iv*) Illness, treatment, or medical condition arising out of any of the following:

(A) War or act of war, whether declared or undeclared.

(B) Participation in a felony, riot, or insurrection.

(C) Service in the armed forces or units auxiliary to the armed forces.

(D) Suicide, whether or not the individual was sane or insane at the time of the suicide, attempted suicide, or intentionally self-inflicted injury.

(2) Long-term care coverage other than home care coverage may provide that before certain coverages in the policy take effect, care must first be recommended by a person or persons as provided in the policy and approved by the commissioner or prescribed by a licensed treating physician. Long-term care coverage for home care may provide that before coverage for home care in the policy takes effect, care must first be prescribed or recommended by a person or persons as provided in the policy and approved by the commissioner.

Sec. 3907. (1) Each individual long-term care policy shall contain a guaranteed renewable provision. An insurer shall not cancel or otherwise terminate a long-term care insurance policy on the grounds of the age or the deterioration of the mental or physical health of the insured.

(2) Each group long-term care certificate shall contain a conversion provision permitting an individual entitled to benefits under the group certificate to elect to convert from the group certificate to an individual long-term care policy with the option of receiving benefits substantially similar to the prior coverage. An individual shall be entitled to convert to the individual policy at all times except under the following circumstances:

(a) Termination of the individual's group coverage resulted from the individual's failure to make any required payment of premium when due.

(b) The terminating coverage is replaced by other group coverage effective on the day following the termination of the other group coverage.

(3) If existing coverage is converted to or replaced by a long-term care insurance policy with the same insurer, the long-term care insurance policy shall not contain a provision establishing a new limitation period except with respect to an increase in benefits voluntarily selected by the insured. The premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group certificate.

(4) A long-term care insurance policy that provides coverage for care in an intermediate care facility or a skilled nursing facility shall also provide coverage for home care services that is a dollar amount equivalent to at least 1/2 of 1 year's coverage available for nursing home benefits under the policy at the time covered home health services are being received.

Sec. 3909. (1) An insurer shall not offer a long-term care insurance policy unless the insurer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations that are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers shall offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than 1 of the following:

(a) Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5%.

(b) Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be not less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5% for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made.

(c) Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

(2) If the policy is issued to a group, the required offer in subsection (1) shall be made to the group policyholder. However, if the policy is issued to a group defined in section 3901(c)(*iv*) other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

(3) Insurers shall include all of the following information in or with the summary of coverage:

(a) A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.

(b) Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases. An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

(4) This section does not apply to life insurance products that accelerate the death benefit to provide long-term care benefits.

Sec. 3911. (1) A preexisting condition limitation period in a long-term care insurance policy, other than a group long-term care certificate described in section 3901(c)(*i*), shall not exceed 1 of the following:

(a) Six months after the effective date of coverage.

(b) A period of time set by the commissioner if the commissioner has found that a longer limitation period than provided for in subdivision (a) is justified because the group is specially limited by age, group categories, or other specific policy provisions and that the longer limitation period will be in the best interest of the public.

(2) A long-term care insurance policy, other than a group long-term care certificate described in section 3901(c)(*i*), shall not use a definition of preexisting condition that is more restrictive than the definition in section 3901.

(3) The definition of preexisting condition does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, underwrite in accordance with that insurer's established underwriting standards.

(4) Unless otherwise provided in the policy, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until after the limitation period. A long-term care insurance policy shall not exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting conditions beyond the limitation period.

Sec. 3913. (1) A long-term care insurance policy shall not limit or exclude services for home health care benefits in any of the following ways:

(a) By requiring that the insured would need skilled care in a skilled nursing facility if home health care services were not provided.

(b) By requiring that the insured first or simultaneously receive nursing or therapeutic services in a home or community setting before home health care services are covered.

(c) By limiting eligible services to services provided by registered nurses or licensed practical nurses.

(d) By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide or other licensed or certified home care worker acting within the scope of his or her licensure or certification.

(e) By requiring that the insured have an acute condition before home health care services are covered.

(f) By limiting benefits to services provided by medicare-certified agencies or providers.

(2) Home health care coverage may be applied to the nonhome health care benefits provided in the policy when determining maximum coverage under the terms of the policy.

Sec. 3915. A long-term care insurance policy shall not condition benefits on any of the following:

(a) The prior institutionalization of the insured.

(b) Prior receipt of a higher level of institutional care.

Sec. 3917. If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods for similar benefits in the new long-term care policy to the extent that similar exclusions have been satisfied under the original policy.

Sec. 3919. Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care coverage was in force and continues without interruption after termination. An extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period and all other applicable provisions of the policy.

Sec. 3921. (1) All applications for long-term care insurance policies except those that are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the applicant's health condition.

(2) If an application for long-term care insurance contains a question that asks whether the applicant has had medication prescribed by a physician, it shall also ask the applicant to list the medication that has been prescribed.

(3) If any medications listed in an application were known by the insurer or should have been known at the time of application to be directly related to a medical condition for which coverage would otherwise be denied, then the policy shall not be rescinded for that condition.

(4) Except for policies that are guaranteed issue, all of the following apply:

(a) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy:

"Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy."

(b) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy at the time of delivery:

"Caution: The issuance of this long-term care insurance policy is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]"

(c) Prior to issuance of a long-term care policy to an applicant age 80 or older, the insurer shall obtain 1 of the following:

(*i*) A report of a physical examination.

(*ii*) An assessment of functional capacity.

(*iii*) An attending physician's statement.

(*iv*) Copies of medical records.

(5) A copy of the completed application or enrollment form, whichever is applicable, shall be delivered to the insured no later than at the time of delivery of the policy unless it was retained by the applicant at the time of application.

(6) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy rescissions, both state and countrywide, except those the insured voluntarily effectuated, and shall annually furnish this information to the commissioner.

Sec. 3923. (1) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual long-term care insurance policy, all riders or endorsements added to a long-term care insurance 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 individual. 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, except if the increased benefits or coverage are required by law. If a separate additional premium is charged for benefits provided in connection with riders or endorsements, that premium charge shall be set forth in the policy, rider, or endorsement.

(2) A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or words of similar import shall include a definition of the terms and an explanation of the terms in its accompanying summary of coverage.

(3) If a long-term care insurance 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) A long-term care insurance policy containing any limitations or conditions for eligibility shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy and shall label the paragraph "limitations or conditions on eligibility for benefits".

Sec. 3927. (1) Benefits under individual long-term care insurance policies shall be considered reasonable in relation to premiums provided the expected loss ratio is at least 60%, calculated in a manner that provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

(a) Statistical credibility of incurred claims experience and earned premiums.

(b) The period for which rates are computed to provide coverage.

(c) Experienced and projected trends.

(d) Concentration of experience within early policy duration.

(e) Expected claim fluctuation.

(f) Experience refunds, adjustments, or dividends.

(g) Renewability features.

(h) All appropriate expense factors.

(i) Interest.

(j) Experimental nature of the coverage.

(k) Policy reserves.

(*l*) Mix of business by risk classification.

(m) Product features such as long elimination periods, high deductibles, and high maximum limits.

(n) Premiums charged and losses incurred for other similar policies.

(2) This section does not apply to fixed indivisible premium life insurance policies that fund long-term care benefits entirely by accelerating the death benefit.

Sec. 3928. A fixed indivisible premium life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums provided that the policy complies with all of the following provisions:

(a) Premiums required to be paid are fixed and guaranteed for the life of the policy.

(b) The guaranteed cash surrender value is stated in the policy.

(c) The death benefit and long-term care benefits are guaranteed for the life of the policy, and the policy contains the schedule of the guarantees.

(d) The risk charges for mortality and morbidity benefits and any other charges made internally to determine cash value accumulations, if any, are guaranteed not to exceed the maximum charges set forth in the policy.

(e) The interest credited internally to determine cash value accumulations, if any, are guaranteed not to be less than the minimum interest rate set forth in the policy.

(f) The benefits cannot be terminated by the insurer except for nonpayment of premium.

(g) The policy meets the nonforfeiture requirements of chapter 40.

(h) At the time of issue, the policy is accompanied by an illustration that clearly discloses the year-by-year progression of cash values and face amount.

(i) The policy provides that the policy owner is supplied annually with a report showing the current cash value, death benefit, and long-term care benefits, and shows the calculation of the change in the cash value from the previous report by the addition of interest and premium payments, if any, and the deduction of the risk charges and any other charges.

Sec. 3929. The premiums charged to an insured for long-term care insurance shall not increase due to either of the following:

(a) The increasing age of the insured at ages beyond 65.

(b) The duration the insured has been covered under the policy.

Sec. 3930. (1) If long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to those policies, policy reserves for the benefits shall be determined in accordance with section 834(1)(*vii*). Claim reserves shall also be established if the policy or rider is in claim status.

(2) Reserves for policies and riders subject to subsection (1) shall be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations may be used if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

(3) In the development and calculation of reserves for policies and riders subject to subsection (1), due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures, and all other considerations that have an impact on projected claim costs, including, but not limited to, all of the following:

(a) Definition of insured events.

(b) Covered long-term care facilities.

(c) Existence of home convalescence care coverage.

(d) Definition of facilities.

(e) Existence or absence of barriers to eligibility.

(f) Premium waiver provision.

(g) Renewability.

(h) Ability to raise premiums.

(i) Marketing method.

(j) underwriting procedures.

(k) Claims adjustment procedures.

(*l*) Waiting period.

(m) Maximum benefit.

(n) Availability of eligible facilities.

(o) Margins in claim costs.

(p) Optional nature of benefit.

(q) Delay in eligibility for benefit.

(r) Inflation protection provisions.

(s) Guaranteed insurability option.

(4) Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American academy of actuaries.

Sec. 3931. The commissioner may promulgate rules including the following:

(a) Rules establishing standards for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents if provided in the policy, preexisting conditions, termination of insurance, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, definitions of terms, and for full and fair disclosure setting forth the manner, content, and required disclosures.

(b) Rules establishing loss ratio standards for long-term care insurance policies.

Sec. 3933. An insurer that offers long-term care insurance shall provide to a prospective applicant before application and upon request before renewal a summary of coverage and shall obtain an acknowledgment of receipt of the summary on the application form or renewal form by obtaining the applicant's signature. An insurer using direct sales response shall provide the summary of coverage to an applicant in conjunction with the initial application and upon request before renewal. The summary of coverage shall be a free-standing document, using no smaller than 10-point type, and shall not contain advertising material. The summary of coverage shall be in substantially the following form:

(COMPANY NAME)
(ADDRESS: CITY AND STATE)
(TELEPHONE)
LONG-TERM CARE POLICY SUMMARY OF COVERAGE

[Policy number or group master policy and certificate number] Caution: The issuance of this long-term care insurance policy is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises. If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [use 1 of the following:] an individual policy of insurance; a group certificate that was issued in the [indicate jurisdiction in which group certificate was issued].

2. Purpose of the summary of coverage. This summary of coverage provides a very brief description of the important features of the policy. You should compare this summary of coverage to summaries of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the policy contains governing contractual provisions. This means that the policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you read your policy carefully.

3. The following are terms under which the policy may be returned and premium refunded:

(a) Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy.

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy. If the policy contains these provisions, include a description of them.]

4. This is not medicare supplemental coverage. If you are eligible for medicare, review the medicare supplemental buyer's guide available from the insurance company. [For agents] neither [insert company name] nor its agents represent medicare, the federal government, or any state government. [For direct response] [insert company name] is not representing medicare, the federal government, or any state government.

5. Long-term care coverage. Policies of this category are designed to provide coverage for 1 or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community, or in the home. This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

6. Benefits provided by this policy are the following:

Category	Definition	Company Benefits
Skilled nursing care	Requires daily attendance, monitoring, evaluation and/or observation by licensed health personnel in a licensed skilled nursing care facility	$ ____ per day
Maximum days payable		____ days
Intermediate/basic/custodial nursing care	Is care that includes assistance in activities of daily living that can be provided by persons without medical skill in a licensed intermediate or skilled nursing care facility	$ ____ per day
Maximum days payable		____ days
Home health benefits: —Daily benefit —Maximum days payable —Restrictions	Will this policy cover home care and what are the restrictions?	____ Yes ____ No $ ____ per day ____ days
Prior hospitalization	Policies may not require that you be placed in a hospital for a certain number of days before you can receive coverage for nursing home care	
Day benefits begin	After you have entered the nursing home, when will the policy start to pay for coverage?	
Preexisting conditions waiting period	If you have been treated in the last 6 months for a condition, will this policy cover your treatment?	____ Yes ____ No
	Does this policy cover you only after a waiting period?	____ Yes ____ No
	How long is the waiting period?	____ days
Prior approval for coverage	Is prior approval needed before your policy will give you coverage?	____ Yes ____ No
Motor vehicle accidents	Will this policy provide coverage for long-term care needed as a result of a motor vehicle accident?	____ Yes ____ No
Evidence of insurability	Is a physical examination required?	____ Yes ____ No
	Do you have to answer a series of health questions?	____ Yes ____ No
Guaranteed renewal	As long as you pay your premiums on time, the company will continue to insure you.	
Waiver of premium	Are there circumstances under which you receive coverage, but do not have to pay the premium?	____ Yes ____ No

7. This policy may not cover all the expenses associated with your long-term care needs. [Provide a brief specific description of any policy provisions that limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits.]

8. Relationship of cost of care and benefits. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time.

(b) Any automatic benefit adjustment provisions.

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage.

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations.

(e) Describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

9. Terms under which the policy may be continued in force or discontinued.

[(a) Describe the policy renewability provisions.

(b) For group coverage, specifically describe applicable continuation/conversion provisions.

(c) Describe waiver of premium provisions or state that there are no such provisions.

(d) State whether or not the company has a right to change premium, and if such a right exists, describe clearly and concisely each circumstance under which the premium may change.]

10. Organic brain disorders and dementia, including Alzheimer's disease.

[State that the policy provides coverage for insureds who are clinically diagnosed as having dementia or related degenerative illnesses including Alzheimer's disease. Specifically describe each benefit screen or other policy provision that provides preconditions to the availability of policy benefits for such an insured including whether there is a screen for cognitive impairment.]

11. Premium.

[(a) State the total annual premium for the policy.

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium that corresponds to each benefit option.]

12. Additional features.

[(a) Indicate if medical underwriting is used.

(b) Describe other important features.]

I have read this summary and understand that this summary is for my own use and is mine to keep.

_____

Prospective Applicant's Signature

Date _____

Sec. 3935. An application for a long-term care policy shall contain the following statement printed, stamped, or as part of a sticker permanently affixed to the application in capital letters on the first page:

"For additional information about long-term care coverage write to the Michigan insurance bureau, P.O. Box 30220, Lansing, MI 48909 or call the area agency on aging in your community."

Sec. 3937. (1) A long-term care insurance shopper's guide in the format developed by the national association of insurance commissioners, or a guide developed or approved by the commissioner, shall be provided to all prospective applicants of a long-term care insurance policy in the following manner:

(a) For agent solicitations, an agent shall deliver the shopper's guide prior to the presentation of an application or enrollment form.

(b) For direct response solicitations, the shopper's guide shall be presented in conjunction with any application or enrollment form.

(2) Life insurance policies or riders containing long-term care benefits are not required to furnish a shopper's guide pursuant to subsection (1), but shall furnish a summary of coverage as provided in section 3951.

Sec. 3939. (1) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force:

(a) Do you have another long-term care insurance policy or certificate in force?

(b) Do you have other long-term care coverage through a health care corporation or a health maintenance organization?

(c) Did you have another long-term care insurance policy or certificate in force during the last 12 months?

(*i*) If so, with which company?

(*ii*) If that policy lapsed, when did it lapse?

(d) Are you covered by medicaid?

(e) Do you intend to replace any of your medical or health insurance coverage with this policy?

(2) Unless the coverage is sold without an agent, a supplementary application or other form containing the questions in subsection (1) requiring the applicant's and agent's signatures may be used.

(3) With regard to a replacement policy issued to a group under section 3904(c)(*iv*), the questions in subsection (1) may be modified but only to the extent necessary to elicit information about health or long-term care insurance policies other than the group certificate being replaced and provided that the certificate holder has been notified of the replacement.

(4) Agents shall list any other health insurance policies they have sold to the applicant in the past 5 years and indicate whether or not they are still in force.

(5) Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its agent, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

"Notice to applicant regarding replacement of individual accident and sickness or long-term care insurance

[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 lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name] insurance company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision. Statement to applicant by agent [broker or other representative]: (Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate cannot contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as

though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

(Signature agent, broker, or other representative)
[Typed name and address of agent or broker]

The above "notice to applicant" was delivered to me on:

(Date)

(Applicant's signature)"

(6) Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

"Notice to applicant regarding replacement of accident and sickness or long-term care insurance

[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 lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy issued by [company name] insurance company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate cannot contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within 30 days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company name)"

(7) Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured, and policy number or address including zip code. The notice shall be made within 5 working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

(8) In recommending the purchase or replacement of any long-term care insurance policy or certificate, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

Sec. 3941. Every insurer providing long-term care insurance coverage in this state shall file with the commissioner for review a copy of any written, radio, or television advertisement for long-term care insurance intended for use in this state at least 45 days before the date the insurer desires to use the advertising. The filing shall include a sample or photocopy of all applicable long-term care policies and related forms and the

approval status of the policies and forms. In addition, all advertisements shall be retained by the insurer or other entity for at least 3 years from the date the advertisement was first used.

Sec. 3942. Every insurer marketing long-term care insurance coverage in this state, directly or through its producers, shall do all of the following:

(a) Establish marketing procedures to assure that any comparison of policies by its agents or other producers are fair and accurate.

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

(c) Display prominently by type, stamp, or other appropriate means, on the first page of the outline of coverage and policy the following:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

(d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of such insurance.

(e) Establish auditable procedures for verifying compliance with this section.

Sec. 3942a. (1) Every insurer marketing long-term care insurance in Michigan shall comply with all of the following reporting requirements for the purpose of reviewing more closely agent activities regarding the sale of long-term care insurance:

(a) Maintain records for each agent of that agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales and report annually by June 30 the top 10% of its agents that have the greatest percentages of lapses and replacements.

(b) Report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year.

(c) Report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year.

(2) All reports prepared pursuant to subsection (1) shall be on a statewide basis.

Sec. 3943. (1) Except as otherwise provided in subsection (2), an applicant for long-term care insurance shall have the right to return the policy within 30 days after its delivery and to have the entire premium refunded if, after examination of the policy, the applicant is not satisfied for any reason and benefits have not been incurred under the policy. Long-term care insurance policies shall have a notice prominently printed on the first page of the policy and the summary of coverage stating in substance that the applicant has the right to return the policy within 30 days after its delivery and to have the entire premium refunded if, after examination of the policy, the applicant is not satisfied for any reason.

(2) A person insured under a long-term care insurance policy issued pursuant to a direct response solicitation shall have the right to return the policy within 30 days after its delivery and to have the entire premium refunded if, after examination, the insured person is not satisfied for any reason. Long-term care insurance policies issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page of the policy and the summary of coverage stating in substance that the insured person shall have the right to return the policy within 30 days after its delivery and to have the entire premium refunded if, after examination, the insured person is not satisfied for any reason. As used in this section, "direct response solicitation" means solicitation in which a representative of the insurer 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.

Sec. 3945. In addition to any other penalties provided by the laws of this state, any insurer and any agent found to have violated any requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to 3 times the amount of any commissions paid for each policy involved in the violation or up to $10,000.00, whichever is greater.

Sec. 3949. (1) An insurer that has both life and disability authority in this state may market policies containing both life benefits and long-term care benefits.

(2) Except as otherwise provided in this act, if life insurance products contain long-term care benefits, the life insurance benefits in those products shall comply with the requirements of chapters 40 and 44 and the long-term care benefits shall comply with this chapter.

Sec. 3951. (1) A policy summary shall be delivered for a life insurance policy or certificate that provides long-term care benefits. The summary shall comply with the requirements in section 3933. For direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request and shall make the delivery no later than at the time of policy delivery. In addition to the policy summary provisions in section 3933, the policy summary shall include all of the following:

(a) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits.

(b) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, if any, for each covered person.

(c) Any exclusions, reductions, and limitations on benefits of long-term care.

(d) If applicable to the policy type, the summary shall also include all of the following:

(*i*) A disclosure of the effects of exercising other rights under the policy.

(*ii*) A disclosure of guarantees related to long-term care costs of insurance charges.

(*iii*) Current and projected maximum lifetime benefits.

(2) If a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include all of the following:

(a) Any long-term care benefits paid out during the month.

(b) An explanation of any changes in the policy, for example, death benefits or cash values due to long-term care benefits being paid out.

(c) The amount of long-term care benefits existing or remaining.

Sec. 3953. A life insurance policy that provides an accelerated benefit for long-term care shall provide a disclosure statement at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted stating that receipt of accelerated benefits may be taxable and that assistance should be sought from a personal tax adviser. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents.

Sec. 3955. Each insurance policy that is advertised, marketed, or offered as long-term care insurance or nursing home insurance shall comply with this chapter and the other applicable provisions of this act.

Sec. 8199a. A fraternal benefit society transacting business in this state and not exempt from the provisions of this chapter under section 8199 shall also be subject to the following additional chapters and provisions of this code, as applicable:

(a) Chapter 1 and chapter 2. However, as to section 240, only subsection (1)(c), (d), (h), and (j) shall apply, except as provided in section 5222.

(b) Sections 403, 405a, 436, 436a, 437, 476a, 5222, and 5256.

(c) Chapters 9, 34, 38, 39, 40 except as to section 4004, and 81.

Section 2. Sections 2264a to 2290 of Act No. 218 of the Public Acts of 1956, being sections 500.2264a to 500.2290 of the Michigan Compiled Laws, are repealed.

Section 3. Sections 1204b and 1204c of Act No. 218 of the Public Acts of 1956, as amended by this amendatory act, shall take effect January 1, 1993.

This act is ordered to take immediate effect.

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Clerk of the House of Representatives.

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Secretary of the Senate.

Approved.....

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Governor.