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

500.3830 Eligible person; requirements.

Sec. 3830. (1) An eligible person is an individual described in subsection (2) who applies to enroll under a medicare supplement policy during the period described in subsection (3), and who submits evidence of the date of termination or disenrollment or medicare part D enrollment with the application for a medicare supplement policy. For an eligible person, an insurer shall not deny or condition the issuance or effectiveness of a medicare supplement policy described in subsections (5), (6), and (7) that is offered and is available for issuance to new enrollees by the insurer, shall not discriminate in the pricing of the medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under the medicare supplement policy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) Upon first becoming eligible for benefits under part A of medicare at age 65, enrolls in a medicare

advantage plan under part C of medicare, or with a PACE provider under section 1894 of the social security act, and disenrolls from the plan or program by not later than 12 months after the effective date of enrollment.

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

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

(a) For an individual described in subsection (2)(a), the guaranteed issue time period begins on the date the individual receives a notice of termination or cessation of all supplemental health benefits or, if a notice is not received, notice that a claim has been denied because of a termination or cessation, or the date that the applicable coverage terminates or ceases, whichever occurs later, and ends 63 days after that date.

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

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

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

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

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

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

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

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

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

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

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

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

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