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 $952	$952 (Part A Deductible)	$0

61st thru 90th day	All but $238 a day	$238 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $476 a day	$476 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 $119 a day	Up to $119 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 $124 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 $124 of Medicare Approved Amounts*	$0	$0	$124 (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 $124 of Medicare Approved Amounts*	$0	$0	$124 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—			
Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE			
Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $124 of Medicare Approved Amounts*	$0	$0	$124 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL— Not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN 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 $952	$952 (Part A Deductible)	$0
61st thru 90th day	All but $238 a day	$238 a day	$0
91st day and after —While using 60 lifetime reserve days	All but $476 a day	$476 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 $119 a day	Up to $119 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 I

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

*Once you have been billed $124 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 $124 of Medicare Approved Amounts*	$0	$0	$124 (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 $124 of Medicare Approved Amounts*	$0	$0	$124 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—			
Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies —Durable medical equipment	100%	$0	$0

First $124 of Medicare Approved Amounts*	$0	$0	$124 (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 J OR HIGH DEDUCTIBLE 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.

**This high deductible plan pays the same benefits as plan J after you have paid a calendar year ($1,790) deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are $1,790. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes medicare deductibles for part A and part B, but does not include the plan's outpatient prescription drug deductible or separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1,790 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $1,790 DEDUCTIBLE**, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $952	$952 (Part A Deductible)	$0
61st thru 90th day	All but $238 a day	$238 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $476 a day	$476 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 $119 a day	Up to $119 a day	$0
101st day and after	$0	$0	All costs

BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

***Notice: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount medicare would have paid for up to an additinal 365 days as provided in the policy's "core benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount medicare would have paid.

PLAN J

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

*Once you have been billed $124 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year. **This high deductible plan pays the same benefits as plan J after you have paid a calendar year ($1,790) deductible. Benefits from the high deductible plan J will not begin until out-of-pocket expenses are $1,790. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes medicare deductibles for part A and part B, but does not include the plan's separate outpatient prescription drug deductible or foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1,790 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $1,790 DEDUCTIBLE**, YOU PAY
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
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 $124 of Medicare Approved Amounts*	$0	$124 (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 $124 of Medicare Approved Amounts*	$0	$124 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—			
Tests for diagnostic services	100%	$0	$0

PARTS A & B

HOME HEALTH CARE			
Medicare Approved Services			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $124 of Medicare Approved Amounts*	$0	$124 (Part B Deductible)	$0
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 beginning 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
PREVENTIVE MEDICAL CARE BENEFIT— Not covered by Medicare Annual physical and preventive tests and services 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 K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $4,000 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			

First 60 days	All but $952	$476 (50% of Part A Deductible)	$476 (50% of Part A Deductible)♦
61st thru 90th day	All but $238 a day	$238 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $476 a day	$476 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 $119 a day	Up to $59.50 a day	Up to $59.50 a day♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%♦
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	Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments♦

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN K

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

****Once you have been billed $124 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 $124 of Medicare Approved Amounts****	$0	$0	$124 (Part B Deductible) ****♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $4,000)*
BLOOD			
First 3 pints	$0	50%	50%♦
Next $124 of Medicare Approved Amounts****	$0	$0	$124 (Part B Deductible) ****♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%♦

CLINICAL LABORATORY SERVICES— Tests for diagnostic services	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $4,000 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $124 of Medicare Approved Amounts*****	$0	$0	$124 (Part B Deductible)♦
Remainder of Medicare Approved Amounts	80%	10%	10%♦

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

PLAN L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $2,000 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN L

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			

First 60 days	All but $952	$714 (75% of Part A Deductible)	$238 (25% of Part A Deductible)♦
61st thru 90th day	All but $238 a day	$238 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $476 a day	$476 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 $119 a day	Up to $89.25 a day	Up to $29.75 a day♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25%♦
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	Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments♦

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

****Once you have been billed $124 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 $124 of Medicare Approved Amounts****	$0	$0	$124 (Part B Deductible) ****♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $2,000)*
BLOOD			
First 3 pints	$0	75%	25%♦
Next $124 of Medicare Approved Amounts****	$0	$0	$124 (Part B Deductible)♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES—			
Tests for diagnostic services	100%	$0	$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $2,000 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

	PARTS A & B		
HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $124 of Medicare Approved Amounts	$0	$0	$124 (PartB Deductible)♦
Remainder of Medicare Approved Amounts	80%	15%	5%♦

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

500.3817 Medicare select policies and certificates; definitions; requirements for issuance; plan of operation; filing, format, and contents; proposed changes; updated list of network providers; payment for covered services not available through network providers; disclosure; receipt of information; grievance procedure; report; availability of comparable or lesser benefits; continuation of coverage; requests for data by state or federal agencies.

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

(2) As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(*i*) The formal organizational structure.

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

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

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

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

(g) Any other information requested by the commissioner.

(7) A medicare select insurer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing any changes. An updated list of network providers shall be filed with the commissioner at least quarterly. Changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

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

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

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

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

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

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

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

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

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

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

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

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

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

(14) At the request of an individual insured under a medicare select policy or certificate, a medicare select insurer shall make available to the individual insured the opportunity to purchase a medicare supplement policy or certificate offered by the insurer that has comparable or lesser benefits and that does not contain a restricted network provision. The insurer shall make the policies or certificates available without requiring evidence of insurability after the medicare supplement policy or certificate has been in force for 6 months. For the purposes of this subsection, a medicare supplement policy or certificate shall be

considered to have comparable or lesser benefits unless it contains 1 or more significant benefits not included in the medicare select policy or certificate being replaced. For the purposes of this subsection, a significant benefit means coverage for the medicare part A deductible, coverage for at-home recovery services, or coverage for part B excess charges.

(15) Medicare select policies and certificates shall provide for continuation of coverage if the secretary of health and human services determines that medicare select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the medicare select program to be reauthorized under law or its substantial amendment. Each medicare select insurer shall make available to each individual insured under a medicare select policy or certificate the opportunity to purchase any medicare supplement policy or certificate offered by the insurer that has comparable or lesser benefits and that does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability. For the purposes of this subsection, a medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains 1 or more significant benefits not included in the medicare select policy or certificate being replaced. For the purposes of this subsection, a significant benefit means coverage for the medicare part A deductible, coverage for at-home recovery service, or coverage for part B excess charges.

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

500.3819 Minimum standards; suspension of benefits and premiums; notice; reinstitution.

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. Receipt of medicare part D benefits will not be considered in determining a continuous loss.

(f) If a medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the medicare prescription drug, improvement, and modernization act of 2003, Public Law 108-173, the modified policy shall be considered to satisfy the guaranteed renewal of this subsection.

(g) A medicare supplement policy shall not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(3) A medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder or certificate holder for a period not to exceed 24 months in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under medicaid, but only if the policyholder or certificate holder notifies the insurer of such assistance within 90 days after the date the individual becomes entitled to the assistance. Upon receipt of timely notice, the insurer shall return to the policyholder or certificate holder that portion of the premium attributable to the period of medicaid eligibility, subject to adjustment for paid claims. If a suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance under medicaid, the policy shall be automatically reinstituted effective as of the date of termination of the assistance if the policyholder or certificate holder provides notice of loss of medicaid medical assistance within 90 days after the date of the loss and pays the premium attributable to the period effective as of the date of termination of the assistance. Each medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of title II of the social security act, and is covered under a group health plan as defined in section 1862(b)(1)(A)(*v*) of the social security act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted effective as of the date of loss of coverage if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan. All of the following apply to the reinstitution of a medicare supplement policy under this subsection:

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

(b) Reinstituted coverage shall be substantially equivalent to coverage in effect before the date of the suspension. If the suspended medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for medicare part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of the suspension.

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

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

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

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

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

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

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

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

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

Sec. 3827. (1) A medicare supplement insurance policy or certificate 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 currently has medicare supplement, medicare advantage, medicaid coverage, or another health insurance policy or certificate in force or whether a medicare supplement policy or certificate is intended to replace any 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 purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

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

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

(5) If you are eligible for, and have enrolled in, a medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your medicare supplement policy can be suspended,

if requested, while you are covered under the employer or union-based group health plan. If you suspend your medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended medicare supplement policy, or if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in medicare part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

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

[QUESTIONS]

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

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

To the best of your knowledge,

(1) (a) Did you turn age 65 in the last 6 months?

Yes ____ No ____

(b) Did you enroll in medicare part B in the last 6 months?

Yes ____ No ____

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

(2) Are you covered for medical assistance through the state medicaid program?

[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes ____ No ____

If yes,

(a) Will medicaid pay your premiums for this medicare supplement policy?

Yes ____ No ____

(b) Do you receive any benefits from medicaid OTHER THAN payments toward your medicare part B premium?

Yes ____ No ____

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

START ____/____/____ END ____/____/____

(b) If you are still covered under the medicare plan, do you intend to replace your current coverage with this new medicare supplement policy?

Yes ____ No ____

(c) Was this your first time in this type of medicare plan?

Yes ____ No ____

(d) Did you drop a medicare supplement policy to enroll in the medicare plan?

Yes ____ No ____

(4) (a) Do you have another medicare supplement policy in force?

Yes ____ No ____

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

_____

(c) If so, do you intend to replace your current medicare supplement policy with this policy?

Yes ____ No ____

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

Yes ____ No ____

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

_____

_____

_____

_____

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

START ____/____/____ END ____/____/____

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

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

(4) For a direct response insurer, 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 12-point type:

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

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

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

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

(Use additional sheets as necessary.)

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

_____ Additional benefits

_____ No change in benefits, but lower premiums

_____ Fewer benefits and lower premiums

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

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

_____ Other. (Please specify)

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

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

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

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

_____

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

_____

Typed Name and Address of Agent or Broker

_____

(Date)

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

_____

(Date)

_____

(Applicant's Signature)

_____

(Applicant's Printed Name)

_____

(Applicant's Address)
(Policy, Certificate, or Contract Number being Replaced)"

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.

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

Sec. 3831. (1) Each insurer offering 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.

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

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

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

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

(d) The insurer provides certification from an executive officer for the specific insurer or affiliate of the insurer wishing to utilize this option. This certification shall identify the process provided in subdivisions (a) through (c) and shall clearly state that the insurer understands that the commissioner may void this arrangement if the affiliate fails to ensure that eligible policyholders are immediately offered medicare supplemental policies.

(e) The insurer certifies to the commissioner that it is in the process of discontinuing in Michigan its offering of individual or group expense incurred hospital, medical, or surgical policies or certificates.

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

Sec. 3835. (1) 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) An insurer shall not issue a medicare supplement policy or certificate to an individual enrolled in medicare advantage unless the effective date of the coverage is after the termination date of the individual's medicare advantage coverage.

(5) A medical supplement policy 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.".

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

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

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

(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.

(5) If a medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the medicare prescription drug, improvement, and modernization act of 2003, Public Law 108-173, the modified policy shall be considered to satisfy the guaranteed renewal requirements of this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) The inclusion of new or innovative benefits.

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

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

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

(6) Except as provided in subsection (7), an insurer shall continue to make available for purchase any medicare supplement policy form or certificate form issued after the effective date of this chapter that has been approved by the commissioner. A medicare supplement policy form or certificate form shall not be considered to be available for purchase unless the insurer has actively offered it for sale in the previous 12 months.

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

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

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

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

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

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

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

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

Repeal of MCL 550.1451 to 550.1499a.

Enacting section 1. Sections 451 to 499a of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1451 to 550.1499a, are repealed.

This act is ordered to take immediate effect.
Approved December 19, 2006.
Filed with Secretary of State December 20, 2006.

[No. 463]

(HB 5580)

AN ACT to amend 1954 PA 116, entitled "An act to reorganize, consolidate, and add to the election laws; to provide for election officials and prescribe their powers and duties; to prescribe the powers and duties of certain state departments, state agencies, and state and local officials and employees; to provide for the nomination and election of candidates for public office; to provide for the resignation, removal, and recall of certain public officers; to provide for the filling of vacancies in public office; to provide for and regulate primaries and elections; to provide for the purity of elections; to guard against the abuse of the elective franchise; to define violations of this act; to provide appropriations; to prescribe penalties and provide remedies; and to repeal certain acts and all other acts inconsistent with this act," by amending sections 24c and 24d (MCL 168.24c and 168.24d).

The People of the State of Michigan enact:

168.24c Board of county canvassers; members; selection; procedure; vacancy.

Sec. 24c. (1) Selection of the members of the board of county canvassers shall be made from each of the 2 political parties casting the greatest number of votes for secretary of state at the preceding general November election in that county. A political party shall not be represented by more than 2 members on the board of county canvassers at any 1 time.

(2) The county committee of each political party, not later than September 1, 1963 and not later than September 1 of each odd numbered year thereafter, shall submit to the county clerk the names of 3 interested persons for each position to which the party is entitled. In a county having 2 or more congressional districts within its boundaries, the chairpersons of the congressional district committees shall act as the county committee for the purposes of this section and section 24d and shall select 1 of their number to act as chairperson for these purposes.

(3) The county board of commissioners, within 10 days after convening for their annual meeting, shall elect by ballot to each position 1 of the 3 nominees for the position, and the board shall appoint the person to the position. Before electing a nominee to the board of county canvassers under this subsection, the county board of commissioners may request that a nominee provide any of the following in order to determine whether the nominee is qualified for and interested in the position on the board of county canvassers:

(a) A letter signed by the nominee indicating an interest in serving on the board of county canvassers and indicating an intent to discharge the duties of the position on the board of county canvassers to the best of his or her ability.

(b) Prior election experience including canvassing elections.

(c) Information on whether the nominee has been convicted of a felony or election crime.

(4) Failure of the county board of commissioners to appoint 1 of the nominees for a position on the board of county canvassers within 10 days after convening for their annual meeting shall result in a vacancy existing in the position, which shall be filled as provided in section 24d for the filling of vacancies on the board of county canvassers.

168.24d Board of county canvassers; vacancy.

Sec. 24d. (1) If a vacancy occurs in the membership of the board of county canvassers, the county clerk shall immediately give notice of the vacancy to the chairperson of the county committee of the political party entitled to fill the vacancy.

(2) The county committee of the political party entitled to fill a vacancy on the board of county canvassers, within 10 days after receiving information concerning the vacancy, shall nominate 3 interested persons for the position and submit the list of nominees to the county clerk.

(3) The county clerk, within 10 days from receipt of the list of nominees, shall appoint 1 of the nominees to the board of county canvassers. Before appointing a nominee to the board of county canvassers under this subsection, the county clerk may request that a nominee provide any of the following in order to determine whether the nominee is qualified for and interested in the position on the board of county canvassers:

(a) A letter signed by the nominee indicating an interest in serving on the board of county canvassers and indicating an intent to discharge the duties of the position on the board of county canvassers to the best of his or her ability.

(b) Prior election experience including canvassing elections.

(c) Information on whether the nominee has been convicted of a felony or election crime.

(4) A person appointed to fill a vacancy on the board of county canvassers shall serve for the balance of the unexpired term.

This act is ordered to take immediate effect.
Approved December 19, 2006.
Filed with Secretary of State December 20, 2006.

[No. 464]

(HB 5885)

AN ACT to amend 1931 PA 285, entitled "An act to provide for city, village and municipal planning; the creation, organization, powers and duties of planning commissions; the regulation and subdivision of land; and to provide penalties for violation of the provisions of this act," by amending sections 7b, 8, and 8a (MCL 125.37b, 125.38, and 125.38a), sections 7b and 8a as added and section 8 as amended by 2001 PA 265.

The People of the State of Michigan enact:

125.37b Submission of proposed plan to municipal legislative body; approval; notice to certain entities; review and comment; advisory statements.

Sec. 7b. (1) A municipal plan may be adopted as a whole or by successive parts corresponding with major geographical areas of the municipality or with functional subject matter areas of the plan.

(2) After preparing a proposed plan, the municipal planning commission shall submit the proposed plan to the legislative body of the municipality for review and comment. The process of adopting a plan shall not proceed further unless the legislative body of the municipality approves the distribution of the proposed plan.

(3) If the legislative body of the municipality approves the distribution of the proposed plan, it shall notify the secretary of the municipal planning commission and the secretary shall submit a copy of the proposed plan, for review and comment, to all of the following:

(a) The planning commission, or if there is no planning commission, the legislative body, of each city, village, or township located within or contiguous to the municipality.

(b) The regional planning commission, if any, for the region in which the municipality is located, if there is no county planning commission for the county in which the municipality is located. If there is a county planning commission for the county in which the municipality is located, the secretary of the municipal planning commission may submit a copy of the proposed plan to the regional planning commission but is not required to do so.

(c) The county planning commission, or if there is no county planning commission, the county board of commissioners, for the county in which the municipality is located. The secretary of the municipal planning commission shall concurrently submit to the county planning commission a statement that the requirements of subdivision (a) have been met or, if there is no county planning commission, shall submit to the county board of commissioners a statement that the requirements of subdivisions (a) and (b) have been met. The statement shall be signed by the secretary and shall include the name and address of each planning commission or legislative body to which a copy of the proposed plan was submitted under subdivision (a) or (b) and the date of submittal.

(d) Each public utility company and railroad company owning or operating a public utility or railroad within the municipality, and any government entity, that registers its name and address for this purpose with the secretary of the municipal planning commission. An entity that, pursuant to this subdivision, receives a copy of a proposed plan, or of a plan as provided in section 8(5), shall reimburse the municipality for any copying and postage costs thereby incurred by the municipality.

(4) An entity described in subsection (3) may submit comments on the proposed plan to the municipal planning commission within 63 days after the proposed plan was submitted to that entity under subsection (3). If the county planning commission or the county board of commissioners that receives a copy of the proposed plan under subsection (3)(c) submits comments, the comments shall include, but need not be limited to, both of the following, as applicable:

(a) A statement whether the county planning commission or county board of commissioners considers the proposed plan to be inconsistent with the plan of any city, village, township, or region described in subsection (3)(a) or (b).

(b) If the county has a county plan, a statement whether the county planning commission considers the proposed plan to be inconsistent with the county plan.

(5) The statements provided for in subsection (4)(a) and (b) are advisory only.

125.38 Municipal planning commission; public hearing; notice; resolution; submission of plan to legislative body; rejection or approval; final adoption.

Sec. 8. (1) Before approving a proposed municipal plan, the municipal planning commission shall hold not less than 1 public hearing on the proposed plan. The hearing shall be held after the expiration of the deadline for comment under section 7b(4). The planning

commission shall give notice of the time and place of the public hearing not less than 15 days before the hearing by 1 publication in a newspaper of general circulation in the municipality and in the official gazette, if any, of the municipality. The planning commission shall also submit notice to each entity described in section 7a(2).

(2) The approval of the plan shall be by resolution of the planning commission carried by the affirmative votes of not less than 2/3 of the members of the planning commission. The resolution shall refer expressly to the maps and descriptive and other matter intended by the planning commission to form the plan or part of the plan, and the action taken shall be recorded on the map and plan and descriptive matter and signed by the chairperson or the secretary of the planning commission. Following approval of the proposed plan by the municipal planning commission, the secretary of the planning commission shall submit a copy of the proposed plan to the legislative body of the municipality.

(3) Approval of the plan by the planning commission under subsection (2) is the final step for adoption of the plan, unless the legislative body by resolution has asserted the right to approve or reject the plan. In that case, after approval of the plan by the planning commission, the legislative body shall approve or reject the plan.

(4) If the legislative body rejects the proposed plan, the legislative body shall submit to the planning commission a statement of its objections to the proposed plan. The planning commission shall consider the legislative body's objections and revise the proposed plan so as to address those objections. The procedures provided in subsections (1) to (3) and this subsection shall be repeated until a proposed plan is approved by the legislative body.

(5) Upon final adoption of the plan, copies of the adopted plan shall be submitted in the same manner as provided for submitting copies of the proposed plan under section 7b(3).

125.38a Plan amendment or adoption of new plan.

Sec. 8a. (1) An extension, addition, revision, or other amendment to a municipal plan shall be adopted under the same procedure as a plan or a successive part of a plan under sections 7a, 7b, and 8. However, for an amendment other than a revision of the plan, the 63-day period otherwise provided for in section 7b(4) shall be 40 days.

(2) At least every 5 years after adoption of the plan, the planning commission shall review the plan and determine whether to commence the procedure to amend the plan or adopt a new plan.

(3) Until January 9, 2003, a municipality may adopt a plan or an extension, addition, revision, or other amendment to a plan under the procedures provided for by this act that were in effect on January 8, 2003.

This act is ordered to take immediate effect.
Approved December 19, 2006.
Filed with Secretary of State December 20, 2006.

[No. 465]

(HB 5886)

AN ACT to amend 1959 PA 168, entitled "An act to provide for township planning; for the creation, organization, powers and duties of township planning commissions; for the regulation and subdivision of land; and to prescribe penalties and provide remedies," by

amending sections 7b, 8, and 9 (MCL 125.327b, 125.328, and 125.329), section 7b as added and sections 8 and 9 as amended by 2001 PA 263.

The People of the State of Michigan enact:

125.327b Adoption of plan; submission to township board; review and comment; notice to certain entities; submission of comments; advisory statements.

Sec. 7b. (1) A plan may be adopted as a whole or by successive parts corresponding with major geographical areas of the township or with functional subject matter areas of the plan.

(2) After preparing a proposed plan, the township planning commission shall submit the proposed plan to the township board for review and comment.

(3) If the township board approves the distribution of the proposed plan, it shall notify the secretary of the planning commission and the secretary shall submit a copy of the proposed plan, for review and comment, to all of the following:

(a) The planning commission, or if there is no planning commission, the legislative body, of each city, village, or township located within or contiguous to the township.

(b) The regional planning commission, if any, for the region in which the township is located, if there is no county planning commission for the county in which the township is located. If there is a county planning commission for the county in which the township is located, the secretary of the township planning commission may submit a copy of the proposed plan to the regional planning commission but is not required to do so.

(c) The county planning commission, or if there is no county planning commission, the county board of commissioners, for the county in which the township is located. The secretary of the township planning commission shall concurrently submit to the county planning commission a statement that the requirements of subdivision (a) have been met or, if there is no county planning commission, shall submit to the county board of commissioners a statement that the requirements of subdivisions (a) and (b) have been met. The statement shall be signed by the secretary and shall include the name and address of each planning commission or legislative body to which a copy of the proposed plan was submitted under subdivision (a) or (b) and the date of submittal.

(d) Each public utility company and railroad company owning or operating a public utility or railroad within the township, and any government entity, that registers its name and address for this purpose with the secretary of the township planning commission. An entity that, pursuant to this subdivision, receives a copy of a proposed plan, or of a plan as provided in section 8(5), shall reimburse the township for any copying and postage costs thereby incurred by the township.

(4) An entity described in subsection (3) may submit comments on the proposed plan to the township planning commission within 63 days after the proposed plan was submitted to that entity under subsection (3). If the county planning commission or the county board of commissioners that receives a copy of the plan under subsection (3)(c) submits comments, the comments shall include, but need not be limited to, both of the following, as applicable:

(a) A statement whether the county planning commission or county board of commissioners considers the proposed plan to be inconsistent with the plan of any city, village, township, or region described in subsection (3)(a) or (b).

(b) If the county has a county plan, a statement whether the county planning commission considers the proposed basic plan to be inconsistent with the county plan.

(5) The statements provided for in subsection (4)(a) and (b) are advisory only.

125.328 Basic plan; public hearing approval procedure; approval by township board; final adoption.

Sec. 8. (1) Before approving a proposed basic plan, the township planning commission shall hold a public hearing on the proposed plan. The hearing shall be held after the expiration of the deadline for comment under section 7b(4). The township planning commission shall publish notice of the hearing twice in a newspaper of general circulation in the township. The first publication shall be not more than 30 days or less than 20 days before the date of the hearing. The second publication shall be not more than 8 days before the date of the hearing.

(2) At or after the hearing under subsection (1), the township planning commission may approve the proposed plan by majority vote of its membership. Following approval of the proposed plan by the township planning commission, the secretary of the planning commission shall submit a copy of the proposed plan to the township board.

(3) Approval of the plan by the planning commission under subsection (2) is the final step for adoption of the plan, unless the township board by resolution has asserted the right to approve or reject the plan. In that case, after approval of the plan by the planning commission, the township board shall approve or reject the plan.

(4) If the township board rejects the proposed plan, the township board shall submit to the planning commission a statement of its objections to the proposed plan. The planning commission shall consider the township board's objections and revise the proposed plan so as to address those objections. The procedures provided in subsections (1) to (3) and this subsection shall be repeated until a proposed plan is approved by the township board.

(5) The plan is effective upon final adoption. Upon final adoption of the plan, copies of the adopted plan shall be submitted in the same manner as provided for submitting copies of the proposed plan under section 7b(3).

125.329 Plan amendment or adoption of new plan.

Sec. 9. (1) An extension, addition, revision, or other amendment to a basic plan shall be adopted under the same procedure as a plan or a successive part of a plan under sections 7a, 7b, and 8. However, for an amendment other than a revision of the plan, the 63-day period otherwise provided for in section 7b(4) shall be 40 days.

(2) At least every 5 years after adoption of the plan, the planning commission shall review the plan and determine whether to commence the procedure to amend the plan or adopt a new plan.

(3) Until January 9, 2003, a township may adopt a plan or an extension, addition, revision, or other amendment to a plan under the procedures provided for by this act that were in effect on January 8, 2003.

(4) The planning commission shall promote public understanding of and interest in the plan, shall publish and distribute copies of the plan and of any report, and may employ such other means of publicity and education as it determines necessary.

This act is ordered to take immediate effect.

Approved December 19, 2006.

Filed with Secretary of State December 20, 2006.

[No. 466]

(HB 5960)

AN ACT to amend 1994 PA 451, entitled "An act to protect the environment and natural resources of the state; to codify, revise, consolidate, and classify laws relating to the environment and natural resources of the state; to regulate the discharge of certain substances into the environment; to regulate the use of certain lands, waters, and other natural resources of the state; to prescribe the powers and duties of certain state and local agencies and officials; to provide for certain charges, fees, assessments, and donations; to provide certain appropriations; to prescribe penalties and provide remedies; and to repeal acts and parts of acts," by amending section 78101 (MCL 324.78101), as amended by 2004 PA 587, and by adding section 78117.

The People of the State of Michigan enact:

324.78101 Definitions.

Sec. 78101. As used in this part:

(a) "Commission" means the Michigan state waterways commission.

(b) "Department" means the department of natural resources.

(c) "Director" means the administrative director of the commission.

(d) "Diesel motor fuel" means any liquid fuel used in the operation of engines of the diesel type in motor vehicles or watercraft.

(e) "Gasoline" means gasoline, casing head or natural gasoline, benzole, benzine, and naphtha; also, any liquid prepared, advertised, offered for sale, sold for use as, or used for, the generation of power for the propulsion of motor vehicles or watercraft, including any product obtained by blending together any 1 or more products of petroleum, with or without other products, and regardless of the original character of the petroleum products blended, if the resultant product obtained is capable of use for the generation of power for the propulsion of motor vehicles or watercraft, it being the intention that the blending of the products, regardless of name or characteristics, shall conclusively be presumed to produce motor fuel, unless the resultant product is entirely incapable for use as motor fuel. Gasoline does not include diesel fuel, liquefied petroleum gas, or commercial or industrial naphthas or solvents manufactured, imported, received, stored, distributed, sold, or used exclusively for purposes other than as a fuel for motor vehicles or watercraft.

(f) "Harbor" means a portion of a lake or other body of water either naturally or artificially protected so as to be a place of safety for watercraft, including contrivances used or designed for navigation on water and used or owned by the United States.

(g) "Harbor facilities" means the structures at a harbor constructed to protect the lake or body of water and the facilities provided within the harbor and ashore for the mooring and servicing of watercraft and the servicing of crews and passengers.

(h) "Inland lake or stream" means that term as defined in section 30101.

(i) "Liquefied petroleum gas" means gases derived from petroleum or natural gases that are in the gaseous state at normal atmospheric temperature and pressure, but that may be maintained in the liquid state at normal atmospheric temperature by suitable pressure.

(j) "Marina" means a site that contains harbor facilities.

(k) "Navigable water" means any waterway navigable by vessels, or capable of being made navigable by vessels through artificial improvements, and includes the structures and facilities created to facilitate navigation.

(*l*) "Person" includes any individual, partnership, corporation, association, or body politic, except the United States and this state, and includes any trustee, receiver, assignee, or other similar representative of those entities.

(m) "Public boating access site" means a publicly owned site for the launching of recreational watercraft.

(n) "Retail fuel dealer" includes any person or persons, both private and municipal, who engage in the business of selling or distributing fuel within this state.

(o) "Secretary of state" means the secretary of state of this state, acting directly or through a duly authorized deputy, investigators, agents, and employees.

(p) "Vessel" means all watercraft except the following:

(*i*) Watercraft used for commercial fishing.

(*ii*) Watercraft used by the sea scout department of the boy scouts of America chiefly for training scouts in seamanship.

(*iii*) Watercraft owned by this state, any political subdivision of this state, or the federal government.

(*iv*) Watercraft when used in interstate or foreign commerce and watercraft used or owned by any railroad company or railroad car ferry company.

(*v*) Watercraft when used in trade, including watercraft when used in connection with an activity that constitutes a person's chief business or means of livelihood.

(q) "Watercraft" means any contrivance used or designed for navigation on water, including, but not limited to, any vessel, ship, boat, motor vessel, steam vessel, vessel operated by machinery, motorboat, sailboat, barge, scow, tugboat, and rowboat, but does not include contrivances used or owned by the United States.

(r) "Waterway" means any body of water.

(s) "Waterways account" means the waterways account of the Michigan conservation and recreation legacy fund provided for in section 2035. This subdivision does not apply unless 2004 PA 587 takes effect, as a result of Joint Resolution Z of the 92nd Legislature becoming a part of the state constitution of 1963 as provided in section 1 of article XII of the state constitution of 1963.

324.78117 Township ordinances regulating activities at public boating access site; scope.

Sec. 78117. A township may by ordinance regulate activities at a public boating access site owned by the department and located on an inland lake or stream. However, the scope of the ordinance shall not exceed the scope of applicable rules promulgated or orders issued by the department under section 504.

This act is ordered to take immediate effect.
Approved December 19, 2006.
Filed with Secretary of State December 20, 2006.

[No. 467]

(HB 6303)

AN ACT to amend 1996 PA 381, entitled "An act to authorize municipalities to create a brownfield redevelopment authority to facilitate the implementation of brownfield plans;

to create brownfield redevelopment zones; to promote the revitalization, redevelopment, and reuse of certain property, including, but not limited to, tax reverted, blighted, or functionally obsolete property; to prescribe the powers and duties of brownfield redevelopment authorities; to permit the issuance of bonds and other evidences of indebtedness by an authority; to authorize the acquisition and disposal of certain property; to authorize certain funds; to prescribe certain powers and duties of certain state officers and agencies; and to authorize and permit the use of certain tax increment financing," by amending section 13 (MCL 125.2663), as amended by 2006 PA 32.

The People of the State of Michigan enact:

125.2663 Brownfield plan; provisions.

Sec. 13. (1) Subject to section 15, the board may implement a brownfield plan. The brownfield plan may apply to 1 or more parcels of eligible property whether or not those parcels of eligible property are contiguous and may be amended to apply to additional parcels of eligible property. Except as otherwise authorized by this act, if more than 1 parcel of eligible property is included within the plan, the tax increment revenues under the plan shall be determined individually for each parcel of eligible property. Each plan or an amendment to a plan shall be approved by the governing body of the municipality and shall contain all of the following:

(a) A description of the costs of the plan intended to be paid for with the tax increment revenues or, for a plan for eligible properties qualified on the basis that the property is owned or under the control of a land bank fast track authority, a listing of all eligible activities that may be conducted for 1 or more of the eligible properties subject to the plan.

(b) A brief summary of the eligible activities that are proposed for each eligible property or, for a plan for eligible properties qualified on the basis that the property is owned or under the control of a land bank fast track authority, a brief summary of eligible activities conducted for 1 or more of the eligible properties subject to the plan.

(c) An estimate of the captured taxable value and tax increment revenues for each year of the plan from each parcel of eligible property, or from all eligible properties qualified on the basis that the property is owned or under the control of a land bank fast track authority, and in the aggregate. The plan may provide for the use of part or all of the captured taxable value, including deposits in the local site remediation revolving fund, but the portion intended to be used shall be clearly stated in the plan. The plan shall not provide either for an exclusion from captured taxable value of a portion of the captured taxable value or for an exclusion of the tax levy of 1 or more taxing jurisdictions unless the tax levy is excluded from tax increment revenues in section 2(dd), or unless the tax levy is excluded from capture under section 15.

(d) The method by which the costs of the plan will be financed, including a description of any advances made or anticipated to be made for the costs of the plan from the municipality.

(e) The maximum amount of note or bonded indebtedness to be incurred, if any.

(f) The duration of the brownfield plan for eligible activities on eligible property, including the beginning date of the capture of tax increment revenues, which beginning date shall not be later than 5 years following the date of the resolution approving the plan amendment related to a particular eligible property and which duration shall not exceed the lesser of the period authorized under subsections (4) and (5) or 30 years.

(g) An estimate of the impact of tax increment financing on the revenues of all taxing jurisdictions in which the eligible property is located.

(h) A legal description of each parcel of eligible property to which the plan applies, a map showing the location and dimensions of each eligible property, a statement of the characteristics that qualify the property as eligible property, and a statement of whether personal property is included as part of the eligible property. If the project is on property that is functionally obsolete, the taxpayer shall include, with the application, an affidavit signed by a level 3 or level 4 assessor, that states that it is the assessor's expert opinion that the property is functionally obsolete and the underlying basis for that opinion.

(i) Estimates of the number of persons residing on each eligible property to which the plan applies and the number of families and individuals to be displaced. If occupied residences are designated for acquisition and clearance by the authority, the plan shall include a demographic survey of the persons to be displaced, a statistical description of the housing supply in the community, including the number of private and public units in existence or under construction, the condition of those in existence, the number of owner-occupied and renter-occupied units, the annual rate of turnover of the various types of housing and the range of rents and sale prices, an estimate of the total demand for housing in the community, and the estimated capacity of private and public housing available to displaced families and individuals.

(j) A plan for establishing priority for the relocation of persons displaced by implementation of the plan.

(k) Provision for the costs of relocating persons displaced by implementation of the plan, and financial assistance and reimbursement of expenses, including litigation expenses and expenses incident to the transfer of title, in accordance with the standards and provisions of the uniform relocation assistance and real property acquisition policies act of 1970, Public Law 91-646.

(*l*) A strategy for compliance with 1972 PA 227, MCL 213.321 to 213.332.

(m) A description of proposed use of the local site remediation revolving fund.

(n) Other material that the authority or governing body considers pertinent.

(2) The percentage of all taxes levied on a parcel of eligible property for school operating expenses that is captured and used under a brownfield plan and all tax increment finance plans under 1975 PA 197, MCL 125.1651 to 125.1681, the tax increment finance authority act, 1980 PA 450, MCL 125.1801 to 125.1830, or the local development financing act, 1986 PA 281, MCL 125.2151 to 125.2174, shall not be greater than the combination of the plans' percentage capture and use of all local taxes levied for purposes other than for the payment of principal of and interest on either obligations approved by the electors or obligations pledging the unlimited taxing power of the local unit of government. This subsection shall apply only when taxes levied for school operating purposes are subject to capture under section 15.

(3) Except as provided in this subsection and subsections (5), (15), and (16), tax increment revenues related to a brownfield plan shall be used only for costs of eligible activities attributable to the eligible property, the captured taxable value of which produces the tax increment revenues, including the cost of principal of and interest on any obligation issued by the authority to pay the costs of eligible activities attributable to the eligible property, and the reasonable costs of preparing a work plan or remedial action plan for the eligible property, including the actual cost of the review of the work plan or remedial action plan under section 15. For property owned or under the control of a land bank fast track authority, tax increment revenues related to a brownfield plan may be used for eligible activities attributable to any eligible property owned or under the control of the land bank fast track authority, the cost of principal of and interest on any obligation issued by the authority to pay the costs of eligible activities, the reasonable costs of preparing a work plan or remedial

action plan, and the actual cost of the review of the work plan or remedial action plan under section 15. Tax increment revenues captured from taxes levied by this state under the state education tax act, 1993 PA 331, MCL 211.901 to 211.906, or taxes levied by a local school district shall not be used for eligible activities described in section 2(m)(*iv*)(E).

(4) Except as provided in subsection (5), a brownfield plan shall not authorize the capture of tax increment revenue from eligible property after the year in which the total amount of tax increment revenues captured is equal to the sum of the costs permitted to be funded with tax increment revenues under this act.

(5) A brownfield plan may authorize the capture of additional tax increment revenue from an eligible property in excess of the amount authorized under subsection (4) during the time of capture for the purpose of paying the costs permitted under subsection (3), or for not more than 5 years after the time that capture is required for the purpose of paying the costs permitted under subsection (3), or both. Excess revenues captured under this subsection shall be deposited in the local site remediation revolving fund created under section 8 and used for the purposes authorized in section 8. If tax increment revenues attributable to taxes levied for school operating purposes from eligible property are captured by the authority for purposes authorized under subsection (3), the tax increment revenues captured for deposit in the local site remediation revolving fund also may include tax increment revenues attributable to taxes levied for school operating purposes in an amount not greater than the tax increment revenues levied for school operating purposes captured from the eligible property by the authority for the purposes authorized under subsection (3). Excess tax increment revenues from taxes levied for school operating purposes for eligible activities authorized under subsection (15) by the Michigan economic growth authority shall not be captured for deposit in the local site remediation revolving fund.

(6) An authority shall not expend tax increment revenues to acquire or prepare eligible property, unless the acquisition or preparation is an eligible activity.

(7) Costs of eligible activities attributable to eligible property include all costs that are necessary or related to a release from the eligible property, including eligible activities on properties affected by a release from the eligible property. For purposes of this subsection, "release" means that term as defined in section 20101 of the natural resources and environmental protection act, 1994 PA 451, MCL 324.20101.

(8) Costs of a response activity paid with tax increment revenues that are captured pursuant to subsection (3) may be recovered from a person who is liable for the costs of eligible activities at an eligible property. This state or an authority may undertake cost recovery for tax increment revenue captured. Before an authority or this state may institute a cost recovery action, it must provide the other with 120 days' notice. This state or an authority that recovers costs under this subsection shall apply those recovered costs to the following, in the following order of priority:

(a) The reasonable attorney fees and costs incurred by this state or an authority in obtaining the cost recovery.

(b) One of the following:

(*i*) If an authority undertakes the cost recovery action, the authority shall deposit the remaining recovered funds into the local site remediation fund created pursuant to section 8, if such a fund has been established by the authority. If a local site remediation fund has not been established, the authority shall disburse the remaining recovered funds to the local taxing jurisdictions in the proportion that the local taxing jurisdictions' taxes were captured.

(*ii*) If this state undertakes a cost recovery action, this state shall deposit the remaining recovered funds into the revitalization revolving loan fund established under section 20108a of the natural resources and environmental protection act, 1994 PA 451, MCL 324.20108a.

(*iii*) If this state and an authority each undertake a cost recovery action, undertake a cost recovery action jointly, or 1 on behalf of the other, the amount of any remaining recovered funds shall be deposited pursuant to subparagraphs (*i*) and (*ii*) in the proportion that the tax increment revenues being recovered represent local taxes and taxes levied for school operating purposes, respectively.

(9) Approval of the brownfield plan or an amendment to a brownfield plan shall be in accordance with the notice and approval provisions of this section and section 14.

(10) Before approving a brownfield plan for an eligible property, the governing body shall hold a public hearing on the brownfield plan. Notice of the time and place of the hearing shall be given by publication twice in a newspaper of general circulation designated by the municipality, the first of which shall be not less than 20 or more than 40 days before the date set for the hearing.

(11) Notice of the time and place of the hearing on a brownfield plan shall contain all of the following:

(a) A description of the property to which the plan applies in relation to existing or proposed highways, streets, streams, or otherwise.

(b) A statement that maps, plats, and a description of the brownfield plan are available for public inspection at a place designated in the notice and that all aspects of the brownfield plan are open for discussion at the public hearing required by this section.

(c) Any other information that the governing body considers appropriate.

(12) At the time set for the hearing on the brownfield plan required under subsection (10), the governing body shall provide an opportunity for interested persons to be heard and shall receive and consider communications in writing with reference to the brownfield plan. The governing body shall make and preserve a record of the public hearing, including all data presented at the hearing.

(13) Not less than 20 days before the hearing on the brownfield plan, the governing body shall provide notice of the hearing to the taxing jurisdictions that levy taxes subject to capture under this act. The authority shall fully inform the taxing jurisdictions about the fiscal and economic implications of the proposed brownfield plan. At that hearing, an official from a taxing jurisdiction with millage that would be subject to capture under this act has the right to be heard in regard to the adoption of the brownfield plan.

(14) The authority shall not enter into agreements with the taxing jurisdictions and the governing body of the municipality to share a portion of the captured taxable value of an eligible property. Upon adoption of the plan, the collection and transmission of the amount of tax increment revenues as specified in this act shall be binding on all taxing units levying ad valorem property taxes or specific taxes against property located in the zone.

(15) Except as provided by subsection (18), if a brownfield plan includes the capture of taxes levied for school operating purposes or the use of tax increment revenues related to a brownfield plan for the cost of eligible activities attributable to more than 1 eligible property that is adjacent and contiguous to all other eligible properties covered by the development agreement, whether or not the captured taxes are levied for school operating purposes, approval of a work plan by the Michigan economic growth authority before January 1, 2008 to use school operating taxes and a development agreement between the municipality and an owner or developer of eligible property are required if the revenues will be used for infrastructure improvements that directly benefit eligible property, demolition of structures

that is not response activity under part 201 of the natural resources and environmental protection act, 1994 PA 451, MCL 324.20101 to 324.20142, lead or asbestos abatement, or site preparation that is not response activity under section 20101 of the natural resources and environmental protection act, 1994 PA 451, MCL 324.20101. The eligible activities to be conducted described in this subsection shall be consistent with the work plan submitted by the authority to the Michigan economic growth authority. The department's approval is not required for the capture of taxes levied for school operating purposes for eligible activities described in this subsection.

(16) The limitations of section 15(1) upon use of tax increment revenues by an authority shall not apply to the following costs and expenses:

(a) In each fiscal year of the authority, $75,000.00 for the following purposes for tax increment revenues attributable to local taxes:

(*i*) Reasonable and actual administrative and operating expenses of the authority.

(*ii*) Baseline environmental assessments, due care activities, and additional response activities related directly to work conducted on prospective eligible properties prior to approval of the brownfield plan.

(b) Reasonable costs of preparing a work plan or remedial action plan or the cost of the review of a work plan for which tax increment revenues may be used under section 13(3).

(17) A brownfield authority may reimburse advances, with or without interest, made by a municipality under section 7(3), a land bank fast track authority, or any other person or entity for costs of eligible activities with any source of revenue available for use of the brownfield authority under this act and may enter into agreements related to those reimbursements. A reimbursement agreement for these purposes and the obligations under that reimbursement agreement shall not be subject to section 12 or the revised municipal finance act, 2001 PA 34, MCL 141.2101 to 141.2821.

(18) If a brownfield plan includes the capture of taxes levied for school operating purposes, approval of a work plan by the Michigan economic growth authority in the manner required under section 15(14) to (16) is required in order to use tax increment revenues attributable to taxes levied for school operating purposes for purposes of eligible activities described in section 2(m)(*iv*)(E) for 1 or more parcels of eligible property. The work plan to be submitted to the Michigan economic growth authority under this subsection shall be in a form prescribed by the Michigan economic growth authority. The eligible activities to be conducted and described in this subsection shall be consistent with the work plan submitted by the authority to the Michigan economic growth authority. The department's approval is not required for the capture of taxes levied for school operating purposes for eligible activities described in this section.

This act is ordered to take immediate effect.
Approved December 19, 2006.
Filed with Secretary of State December 20, 2006.

[No. 468]

(HB 6580)

AN ACT to amend 1939 PA 280, entitled "An act to protect the welfare of the people of this state; to provide general assistance, hospitalization, infirmary and medical care to poor or unfortunate persons; to provide for compliance by this state with the social security act;

to provide protection, welfare and services to aged persons, dependent children, the blind, and the permanently and totally disabled; to administer programs and services for the prevention and treatment of delinquency, dependency and neglect of children; to create a state department of social services; to prescribe the powers and duties of the department; to provide for the interstate and intercounty transfer of dependents; to create county and district departments of social services; to create within certain county departments, bureaus of social aid and certain divisions and offices thereunder; to prescribe the powers and duties of the departments, bureaus and officers; to provide for appeals in certain cases; to prescribe the powers and duties of the state department with respect to county and district departments; to prescribe certain duties of certain other state departments, officers, and agencies; to make an appropriation; to prescribe penalties for the violation of the provisions of this act; and to repeal certain parts of this act on specific dates," by amending sections 57b, 57f, and 57g (MCL 400.57b, 400.57f, and 400.57g), section 57b as amended by 1999 PA 9 and sections 57f and 57g as amended by 2001 PA 280, and by adding sections 57q, 57r, 57t, and 57u.

The People of the State of Michigan enact:

400.57b Family independence assistance; eligibility requirements generally; requirements applicable to minor parent and minor parent's child; recipient applying for supplemental security income and seeking exemption from work first program; evaluation and assessment process; audit.

Sec. 57b. (1) Subject to section 57*l*, an individual who meets all of the following requirements is eligible for family independence assistance:

(a) Is a member of a family or a family independence assistance group.

(b) Is a member of a program group whose income and assets are less than the income and asset limits set by the department.

(c) In the case of a minor parent, meets the requirements of subsection (2).

(d) Is a United States citizen, a permanent resident alien, or a refugee.

(e) Is a resident of this state as described in section 32.

(f) Meets any other eligibility criterion required for the receipt of federal or state funds or determined by the department to be necessary for the accomplishment of the goals of the family independence program.

(2) A minor parent and the minor parent's child shall not receive family independence assistance unless they live in an adult-supervised household. The family independence assistance shall be paid on behalf of the minor parent and child to an adult in the adult-supervised household. Child care in conjunction with participation in education, employment readiness, training, or employment programs, which have been approved by the department, shall be provided for the minor parent's child. The minor parent and child shall live with the minor parent's parent, stepparent, or legal guardian unless the department determines that there is good cause for not requiring the minor parent and child to live with a parent, stepparent, or legal guardian. The department shall determine the circumstances that constitute good cause, based on a parent's, stepparent's, or guardian's unavailability or unwillingness or based on a reasonable belief that there is physical, sexual, or substance abuse, or domestic violence, occurring in the household, or that there is other risk to the physical or emotional health or safety of the minor parent or child. If the department determines that there is good cause for not requiring a minor parent to live with a parent, stepparent, or legal guardian, the minor parent and child shall live in another adult-supervised household. A local office director may waive the requirement set forth in this subsection with respect to a minor

parent who is at least 17 years of age, attending secondary school full-time, and participating in a department service plan or a teen parenting program, if moving would require the minor parent to change schools.

(3) Beginning December 31, 2006, if a recipient who is otherwise eligible for family independence assistance under this section is currently applying for supplemental security income and seeking exemption from the work first program, the recipient shall be evaluated and assessed as provided in this section before a family self-sufficiency plan is developed under section 57e. Based on a report resulting from the evaluation and assessment, the caseworker shall make a determination and referral as follows:

(a) A determination that the recipient is eligible to participate in work first and a referral to the work first program.

(b) A determination that the recipient is exempt from work first participation under section 57f and a referral to a sheltered work environment or subsidized employment.

(c) A determination that the recipient is exempt from work first participation under section 57f and a referral to a legal services organization for supplemental security income advocacy.

(4) The department may contract with a legal services organization to assist recipients with the process for applying for supplemental security income. The department may also contract with a nonprofit rehabilitation organization to perform the evaluation and assessment described under subsection (3). If the department contracts with either a nonprofit legal or rehabilitation services organization, uniform contracts shall be used statewide that include, but are not limited to, uniform rates and performance measures.

(5) The auditor general shall conduct an annual audit of the evaluation and assessment process required under this section and submit a report of his or her findings to the legislature.

400.57f Agreement with department of labor and economic growth; participation in work first program; exemptions; temporary exemptions; disabled individual; rules; section inapplicable after September 30, 2011.

Sec. 57f. (1) The department shall enter into an agreement with the department of labor and economic growth to facilitate the administration of work first. The department shall make information on the program available to the legislature.

(2) Except as provided in section 57b, at the time the department determines that an individual is eligible to receive family independence assistance under this act, the department shall determine whether that individual is eligible to participate in the work first program or if the individual is exempt from work first participation under this section. The particular activities in which the recipient is required or authorized to participate, the number of hours of work required, and other details of work first shall be developed by the department and the department of labor and economic growth and shall be set forth in the recipient's family self-sufficiency plan. If a recipient has cooperated with work first, the recipient may enroll in a program approved by the local workforce development board. Any and all training or education with the exception of high school completion, GED preparation, and literacy training must be occupationally relevant and in demand in the labor market as determined by the local workforce development board and may be no more than 2 years in duration. Participants must make satisfactory progress while in training or education.

(3) The following individuals are exempt from participation in work first:

(a) A child under the age of 16.

(b) A child aged 16 or older, or a minor parent, who is attending elementary or secondary school full-time.

(c) The parent of a child under the age of 3 months. The family independence agency may require a parent exempted from participation in work first under this subdivision to participate in family services, including, but not limited to, instruction in parenting, nutrition, and child development beginning 6 weeks after the birth of his or her child until the child is 3 months old as fulfillment of that parent's social contract obligation under section 57e(1)(c).

(d) An individual aged 65 or older.

(e) A recipient of supplemental security income.

(f) An individual who meets 1 or more of the following criteria to the extent that the individual, based on medical evidence and an assessment of need by the department, is severely restricted in his or her ability to participate in employment or training activities:

(*i*) A recipient of social security disability, or medical assistance due to disability or blindness.

(*ii*) An individual suffering from a physical or mental impairment that meets federal supplemental security income disability standards, except that no minimum duration is required.

(*iii*) The spouse of an individual described in subparagraph (*i*) or (*ii*) who is the full-time caregiver of that individual.

(*iv*) A parent or caretaker of a child who is suffering from a physical or mental impairment that meets the federal supplemental security income disability standards, except that no minimum duration is required.

(g) Beginning April 1, 2007, the parent of a child under the age of 3 months. The department may require a parent exempted from participation in work first under this subdivision to participate in family services, including, but not limited to, instruction in parenting, nutrition, and child development beginning 6 weeks after the birth of his or her child until the child is 3 months old as fulfillment of that recipient's family self-sufficiency plan obligation under section 57e(1)(c).

(h) Beginning April 1, 2007, a recipient of supplemental security income.

(i) Beginning April 1, 2007, an individual who meets 1 or more of the following criteria to the extent that the individual, based on medical evidence and an assessment of need by the department, is severely restricted in his or her ability to participate in employment or training activities:

(*i*) A recipient of social security disability, or medical assistance due to disability or blindness.

(*ii*) An individual suffering from a physical or mental impairment that meets federal supplemental security income disability standards, except that no minimum duration is required.

(*iii*) The spouse of an individual described in subparagraph (*i*) or (*ii*) who is the full-time caregiver of that individual.

(*iv*) A parent or caretaker of a child who is suffering from a physical or mental impairment that meets the federal supplemental security income disability standards, except that no minimum duration is required.

(*v*) An individual with low intellectual capacity or learning disabilities that impede comprehension and prevent success in acquiring basic reading, writing, and math skills, including, but not limited to, an individual with an intelligence quotient less than 80.

(*vi*) An individual with documented chronic mental health problems that cannot be controlled through treatment or medication.

(*vii*) An individual with physical limitations on his or her ability to perform routine manual labor tasks, including, but not limited to, bending or lifting, combined with intellectual capacity or learning disabilities.

(4) In addition to those individuals exempt under subsection (3), the department may grant a temporary exemption from participation in work first, not to exceed 90 days, to an individual who is suffering from a documented short-term mental or physical illness, limitation, or disability that severely restricts his or her ability to participate in employment or training activities. An individual with a documented mental or physical illness, limitation, or disability that does not severely restrict his or her ability to participate in employment or training activities shall be required to participate in work first at a medically permissible level.

(5) An individual is not disabled for purposes of this section if substance abuse is a contributing factor material to the determination of disability.

(6) The department may promulgate rules in accordance with the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, identifying exemptions under this section. The director of the department may grant exemptions for extenuating circumstances beyond the exemptions provided for in this section. The department shall annually provide to the legislature, at the same time as the governor's departmental budget proposal, a report of the number of exemptions issued under this section and the individual reason for those exemptions.

(7) This section does not apply after September 30, 2011.

400.57g Failure to comply with rules or provisions; penalties; "noncompliance" defined; termination; "willingness to comply" defined; report; applicability of subsections (1) to (8); applicability of subsections (10) to (15); penalties after April 1, 2007; good cause defined; notification; meeting; section inapplicable after September 30, 2011.

Sec. 57g. (1) The department shall develop a system of penalties to be imposed if a recipient fails to comply with applicable rules or the provisions of this section. Penalties may be cumulative and may include reduction of the grant, removal of an individual from the family independence assistance group, and termination of assistance to the family.

(2) A penalty shall not be imposed if the recipient has demonstrated that there was good cause for failing to comply. The department shall determine the circumstances that constitute good cause based on factors that are beyond the control of a recipient.

(3) Recipients who are willing to participate in activities leading to self-sufficiency but who require child care or transportation in order to participate shall not be penalized if the department determines that child care or transportation is not reasonably available or provided to them.

(4) The system of penalties developed under subsection (1) shall include both of the following:

(a) Family independence program benefits shall be terminated if a recipient fails, without good cause, to comply with applicable child support requirements including efforts to establish paternity and obtain child support. The assistance group is ineligible for family independence program assistance for not less than 1 calendar month. After assistance has been terminated for not less than 1 calendar month, assistance may be restored if the noncompliant recipient complies with child support requirements including the action to establish paternity and obtain child support.

(b) For any instance of noncompliance, before determining that a penalty shall be imposed, the department shall determine if good cause for noncompliance exists. The department shall

notify the recipient that he or she has 10 days to demonstrate good cause for noncompliance. If good cause is not determined to exist, assistance shall be terminated. After termination, the assistance group is ineligible for family independence program assistance for not less than 1 calendar month.

(5) For the purposes of this section, "noncompliance" means 1 or more of the following:

(a) A recipient quits a job.

(b) A recipient is fired for misconduct or for absenteeism without good cause.

(c) A recipient voluntarily reduces the hours of employment or otherwise reduces earnings.

(d) A recipient does not participate in work first activities.

(6) If a recipient does not meet the recipient's individual social contract requirements, the department may impose a penalty.

(7) After termination for noncompliance, the assistance group is ineligible for family independence program assistance for not less than 1 calendar month. After assistance has been terminated for not less than 1 calendar month, family independence program assistance may be approved if the recipient completes a willingness to comply test. For purposes of this section, "willingness to comply" means participating in work first or other self-sufficiency activities for up to 40 hours within 10 working days. At the time any penalty is imposed under this section, the department shall provide the recipient written notice of his or her option to immediately reapply for family independence program benefits and that he or she may complete a "willingness to comply test" during the penalty period.

(8) The department shall submit a report for the period between February 1, 2002 and December 31, 2002 to the legislature, the house and senate fiscal agencies, and the appropriate house and senate standing committees that handle family and children's issues, that contains all of the following information for that time period:

(a) The number of sanctions imposed and reapplications made.

(b) The number of family independence program cases reopened.

(c) The number of referrals to emergency shelters by the department.

(d) The number of sanctions imposed on families with at least 1 disabled parent.

(e) The number of sanctions imposed on families with disabled children.

(9) Subsections (1) to (8) do not apply after March 31, 2007. Subsections (10) to (15) apply beginning April 1, 2007.

(10) Beginning April 1, 2007, if a recipient does not meet his or her individual family self-sufficiency plan requirements and is therefore noncompliant, the department shall impose the penalties described under this section. The department shall implement a schedule of penalties for instances of noncompliance as described in this subsection. The penalties shall be as follows:

(a) For the first instance of noncompliance, the recipient is ineligible to receive family independence program assistance for not less than 3 calendar months.

(b) For the second instance of noncompliance, the recipient is ineligible to receive family independence program assistance for not less than 3 calendar months.

(c) For the third instance of noncompliance, the recipient is ineligible to receive family independence program assistance for 12 calendar months.

(11) For the purposes of this section, "noncompliance" means 1 or more of the following:

(a) A recipient quits a job.