(c) A standardized medicare supplement benefit plan C shall include only the following: the core benefits as defined in section 455, the medicare part A deductible, skilled nursing facility care, medicare part B deductible, and medically necessary emergency care in a foreign country as defined in section 459(1)(a), (b), (c), and (h).

(d) A standardized medicare supplement benefit plan D shall include only the following: the core benefits as defined in section 455, the medicare part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in section 459(1)(a), (b), (h), and (j).

(e) A standardized medicare supplement benefit plan E shall include only the following: the core benefits as defined in section 455, the medicare part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and preventive medical care as defined in section 459(1)(a), (b), (h), and (i).

(f) A standardized medicare supplement benefit plan F shall include only the following: the core benefits as defined in section 455, the medicare part A deductible, skilled nursing facility care, medicare part B deductible, 100% of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 459(1)(a), (b), (c), (e), and (h). A standardized medicare supplement plan F high deductible shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan F deductible. The covered expenses include the core benefits as defined in section 455, plus the medicare part A deductible, skilled nursing facility care, the medicare part B deductible, 100% of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in section 459(1)(a), (b), (c), (e), and (h). The annual high deductible plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan F certificate, and shall be in addition to any other specific benefit deductibles. The annual high deductible plan F deductible is $1,580.00 for calendar year 2001, and the secretary shall adjust it annually thereafter to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, rounded to the nearest multiple of $10.00.

(g) A standardized medicare supplement benefit plan G shall include only the following: the core benefits as defined in section 455, the medicare part A deductible, skilled nursing facility care, 80% of the medicare part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in section 459(1)(a), (b), (d), (h), and (j).

(h) A standardized medicare supplement benefit plan H shall include only the following: the core benefits as defined in section 455, the medicare part A deductible, skilled nursing facility care, basic outpatient prescription drug benefit, and medically necessary emergency care in a foreign country as defined in section 459(1)(a), (b), (f), and (h).

(i) A standardized medicare supplement benefit plan I shall include only the following: the core benefits as defined in section 455, the medicare part A deductible, skilled nursing facility care, 100% of the medicare part B excess charges, basic outpatient prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in section 459(1)(a), (b), (e), (f), (h), and (j).

(j) A standardized medicare supplement benefit plan J shall include only the following: the core benefits as defined in section 455, the medicare part A deductible, skilled nursing facility care, medicare part B deductible, 100% of the medicare part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in section 459(1)(a), (b), (c), (e), (g), (h), (i), and (j). A standardized medicare supplement benefit plan J high deductible plan shall consist of only the following: 100% of covered

expenses following the payment of the annual high deductible plan J deductible. The covered expenses include the core benefits as defined in section 455, plus the medicare part A deductible, skilled nursing facility care, medicare part B deductible, 100% of the medicare part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in section 459(1)(a), (b), (c), (e), (g), (h), (i), and (j). The annual high deductible plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan J certificate, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1,580.00 for calendar year 2001, and the secretary shall adjust it annually thereafter to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, rounded to the nearest multiple of $10.00.

550.1465 Outline of coverage.

Sec. 465. (1) A health care corporation that offers a medicare supplement certificate shall provide an outline of coverage to the applicant at the time of application and, except for direct response solicitation certificates, shall obtain an acknowledgment of receipt of the outline of coverage from the applicant. The outline of coverage provided to applicants pursuant to this section shall consist of the following 4 parts:

(a) A cover page.

(b) Premium information.

(c) Disclosure pages.

(d) Charts displaying the features of each benefit plan offered by the health care corporation.

(2) If an outline of coverage is provided at the time of application and the medicare supplement certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the certificate shall be delivered with the certificate and contain the following statement, in no less than 12-point type, immediately above the company name:

NOTICE: READ THIS OUTLINE OF COVERAGE CAREFULLY. IT IS NOT IDENTICAL TO THE OUTLINE OF COVERAGE PROVIDED UPON APPLICATION AND THE COVERAGE ORIGINALLY APPLIED FOR HAS NOT BEEN ISSUED.

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

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

Medicare supplement coverage can be sold in only 10 standard plans plus 2 high deductible plans. This chart shows the benefits included in each plan. Every health care corporation shall make available Plan "A". Some plans may not be available in your state.

BASIC BENEFITS: Included in All Plans.
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses) or, for hospital outpatient department services under a prospective payment system, applicable copayments.
Blood: First three pints of blood each year.

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

PREMIUM INFORMATION

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

DISCLOSURES

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

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN CERTIFICATE

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

CERTIFICATE REPLACEMENT

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

NOTICE

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

[For agent issued certificates]

Neither (insert health care corporation's name) nor its agents are connected with medicare.

[For direct response issued certificates]

(Insert health care corporation's name) is not connected with medicare.

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

[Include for each plan offered by the health care corporation a chart showing the services, medicare payments, plan payments, and member payments using the same language, in the same order, and using uniform layout and format as shown in the charts that follow. A health care corporation may use additional benefit plan designations on these charts pursuant to section 461(4). Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner. The health care corporation issuing the certificate shall change the dollar amounts each year to reflect current figures. No more than 4 plans may be shown on 1 chart.] Charts for each plan are as follows:

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$0	$792 (Part A Deductible)
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $396 a day	$396 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 $99 a day	$0	Up to $99 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80% (Generally)	20% (Generally)	$0

Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PARTS A & B

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

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$792 (Part A Deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $396 a day	$396 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 $99 a day	$0	Up to $99 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT, such as Physician's services, in-patient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)

Remainder of Medicare Approved Amounts	80% (Generally)	20% (Generally)	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PARTS A & B

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

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$792 (Part A Deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0

91st day and after —While using 60 lifetime reserve days	All but $396 a day	$396 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 $99 a day	Up to $99 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80% (Generally)	20% (Generally)	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAG-NOSTIC SERVICES	100%	$0	$0

(continued)

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			

First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$792 (Part A Deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $396 a day	$396 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 $99 a day	Up to $99 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80% (Generally)	20% (Generally)	$0

Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PARTS A & B

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

		Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

(continued)

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN E

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$792 (Part A Deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $396 a day	$396 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 $99 a day	Up to $99 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN E

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80% (Generally)	20% (Generally)	$0

Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

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

PLAN F OR HIGH DEDUCTIBLE PLAN F

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

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

**This high deductible plan pays the same or offers the same benefits as Plan F after you have paid a calendar year ($1,580) deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $1,580. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the certificate. This includes Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1,580 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $1,580 DEDUCTIBLE**, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$792 (Part A Deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after —While using 60 lifetime reserve days	All but $396 a day	$396 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 $99 a day	Up to $99 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 out-patient drugs and inpatient respite care	$0	Balance

PLAN F

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

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

**This high deductible plan pays the same or offers the same benefits as Plan F after you have paid a calendar year ($1,580) deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $1,580. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the certificate. This includes Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1,580 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $1,580 DEDUCTIBLE**, YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80% (Generally)	20% (Generally)	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	$0	$0

—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$792 (Part A Deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $396 a day	$396 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 $99 a day	Up to $99 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 out-patient drugs and inpatient respite care	$0	Balance

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80% (Generally)	20% (Generally)	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	80%	20%

BLOOD First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PARTS A & B

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

(continued)

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 $792	$792 (Part A Deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $396 a day	$396 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 $99 a day	Up to $99 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN H

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80% (Generally)	20% (Generally)	$0

Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PARTS A & B

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

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%—$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All Costs

PLAN I

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$792 (Part A Deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $396 a day	$396 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 $99 a day	Up to $99 a day	$0
101st day and after	$0	$0	All costs

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

PLAN I

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	 $0 80% (Generally) $0	 $0 20% (Generally) 100%	 $100 (Part B Deductible) $0 $0
BLOOD First 3 pints Next $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All Costs $0 20%	 $0 $100 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PARTS A & B

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

(continued)

OTHER BENEFITS—NOT COVERED BY MEDICARE

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

BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%—$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All Costs

PLAN 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 or offers the same benefits as Plan J after you have paid a calendar year ($1,580) deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are $1,580. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the certificate. This includes Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1,580 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $1,580 DEDUCTIBLE**, YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $792	$792 (Part A Deductible)	$0
61st thru 90th day	All but $198 a day	$198 a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $396 a day	$396 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 $99 a day	Up to $99 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN J

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

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

**This high deductible plan pays the same or offers the same benefits as Plan J after you have paid a calendar year ($1,580) deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are $1,580. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the certificate. This includes Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $1,580 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $1,580 DEDUCTIBLE**, YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies,			

physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80% (Generally)	20% (Generally)	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PARTS A & B

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

(continued)

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
EXTENDED OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $6,000 each calendar year	$0	50%—$3,000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All Costs

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

550.1469 Medicare supplement certificate; minimum standards; notice of medical assistance under medicaid; suspension of benefits and premiums; reinstitution of certificate.

Sec. 469. (1) A certificate shall not be titled, advertised, solicited, or issued for delivery in this state as a medicare supplement certificate if the certificate does not meet the minimum standards prescribed in this section. These minimum standards are in addition to all other requirements of this part.

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

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

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

(e) Termination of a medicare supplement certificate shall not reduce or limit the payment of benefits for any continuous loss that commenced while the certificate was in force, but the extension of benefits beyond the period during which the certificate was in force may be predicated upon the continuous total disability of the member, limited to the duration of the certificate benefit period, if any, or payment of the maximum benefits.

(f) A medicare supplement certificate 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 member, other than the nonpayment of premium.

(3) A medicare supplement certificate shall provide that benefits and premiums under the certificate shall be suspended at the request of the certificate holder for a period not to exceed 24 months in which the certificate holder has applied for and is determined to be entitled to medical assistance under medicaid, but only if the certificate holder notifies the health care corporation of such assistance within 90 days after the date the individual becomes entitled to the assistance. Upon receipt of timely notice, the health care corporation shall return to the 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 certificate holder loses entitlement to medical assistance under medicaid, the certificate shall be automatically reinstituted effective as of the date of termination of the assistance if the 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 certificate shall provide that benefits and premiums under the certificate shall be suspended at the request of the member if the member 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 member loses coverage under the group health plan, the certificate shall be automatically reinstituted effective as of the date of loss of coverage if the member 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 certificate under this subsection:

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

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

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

550.1479 Medicare supplement certificate; denial or conditioning of issuance or discrimination in pricing prohibited; conditions; availability of certificate; excluded benefits based on preexisting condition; prohibition; "creditable coverage" defined.

Sec. 479. (1) A health care corporation shall not deny or condition the issuance or effectiveness of a medicare supplement certificate available for sale in this state, or discriminate in the pricing of such a certificate, because of the health status, claims experience, receipt of health care, or medical condition of an applicant if an application for the certificate is submitted during the 6-month period beginning with the first month in which an individual who is 65 years of age or older first enrolled for benefits under medicare part B. Each medicare supplement certificate currently available from a health care corporation shall be made available to all applicants who qualify under this section without regard to age.

(2) If an applicant qualifies under subsection (1), submits an application during the time period provided in subsection (1), and as of the date of application has had a continuous

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

(3) Except as provided in subsection (2) and section 483, subsection (1) does not prevent the exclusion of benefits under a certificate, during the first 6 months, based on a preexisting condition for which the member received treatment or was otherwise diagnosed during the 6 months before the coverage became effective.

(4) "Creditable coverage" does not include any of the following:

(a) One or more of the following:

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

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

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

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

(*v*) Automobile medical payment insurance.

(*vi*) Credit-only insurance.

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

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

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

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

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

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

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

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

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

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

(*i*) Medicare supplemental policy as defined under section 1882(g)(1) of part D of medicare, 42 U.S.C. 1395ss.

(*ii*) Coverage supplemental to the coverage provided under chapter 55 of title 10 of the United States Code, 10 U.S.C. 1071 to 1109.

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

550.1480 Eligibility provisions.

Sec. 480. (1) An eligible person is an individual described in subsection (2) who applies to enroll under a medicare supplement certificate during the period described in subsection (3), and who submits evidence of the date of termination or disenrollment with the application for a medicare supplement certificate. For an eligible person, a health care corporation shall not deny or condition the issuance or effectiveness of a medicare supplement certificate described in subsections (5), (6), and (7) that is offered and is available for issuance to new enrollees by the health care corporation, shall not discriminate in the pricing of the medicare supplement certificate 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 certificate.

(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+choice organization under a medicare+choice 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+choice 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, a health care prepayment plan, or an organization under a medicare select policy or certificate, 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 or certificate and the enrollment ceases because of any of the following:

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

(*ii*) The insurer or health care corporation substantially violated a material provision of the policy or certificate.

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

(e) Was enrolled under a medicare supplement policy or certificate and terminates enrollment and subsequently enrolls, for the first time, with any medicare+choice organization under a medicare+choice 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 or certificate; and the subsequent enrollment is terminated by the individual during any period within the first 12 months of the subsequent enrollment during which the individual 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+choice 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.

(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, and ends 63 days after the date of the applicable notice.

(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) 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) The medicare supplement certificate to which an eligible person is entitled under subsection (2)(a), (b), (c), and (d) is a medicare supplement certificate that has a benefit package classified as plan a, b, c, or f offered by any health care corporation.

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

(7) The medicare supplement certificate to which an eligible person is entitled under subsection (2)(f) shall include any medicare supplement certificate offered by any health care corporation.

550.1480a Cessation of enrollment; notification.

Sec. 480a. (1) At the time of an event described in section 480(2) because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, certificate, or plan, the organization that terminates the contract or agreement, the insurer terminating the policy, the health care corporation terminating the certificate, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under section 480 and of the obligations of health care corporations of medicare supplement certificates under section 480(1). The notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in section 480(2) because of which an individual ceases enrollment under a contract or agreement, policy, certificate, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the insurer offering the policy, the health care corporation offering the certificate, or the administrator of the plan, respectively, shall notify the individual of his or her rights under section 480 and of the obligations of health care corporations providing medicare supplement certificates under section 480(1). The notice shall be communicated within 10 working days of the health care corporation receiving notification of disenrollment.

Repeal of §§ 550.1216, 550.1217, and 550.1487.

Enacting section 1. Sections 216, 217, and 487 of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.550.1216, 550.1217, and 550.1487, are repealed.

This act is ordered to take immediate effect.
Approved September 27, 2002.
Filed with Secretary of State September 27, 2002.

Compiler's note: Enacting section 1 should evidently reference MCL 550.1216 instead of MCL 550.550.1216.

[No. 560]

(SB 287)

AN ACT to make, supplement, and adjust appropriations for capital outlay and certain state departments for the fiscal year ending September 30, 2002 and the fiscal year ending September 30, 2003; to provide for the expenditure of the appropriations; to prescribe certain conditions for the appropriations; and to repeal acts and parts of acts.

The People of the State of Michigan enact:

PART 1

LINE-ITEM APPROPRIATIONS FOR
FISCAL YEAR 2002-2003

Appropriations; supplemental; capital outlay.

Sec. 101. There is appropriated for capital outlay and for certain state departments for the fiscal year ending September 30, 2003, from the following funds:

APPROPRIATION SUMMARY:		
Full-time equated classified positions....36.7		
GROSS APPROPRIATION	$	12,565,900
Total interdepartmental grants and intradepartmental transfers		0
ADJUSTED GROSS APPROPRIATION	$	12,565,900
Total federal revenues		0
Total local revenues		0
Total private revenues		0
Total other state restricted revenues		12,565,700
State general fund/general purpose	$	200

Department of agriculture.

Sec. 102. DEPARTMENT OF AGRICULTURE		
(1) APPROPRIATION SUMMARY		
Full-time equated classified positions....36.7		
GROSS APPROPRIATION	$	12,565,700
Total interdepartmental grants and intradepartmental transfers		0
ADJUSTED GROSS APPROPRIATION	$	12,565,700
Total federal revenues		0
Total local revenues		0
Total private revenues		0
Total other state restricted revenues		12,565,700
State general fund/general purpose	$	0
(2) FAIRS AND EXPOSITIONS		
Purses and supplements - fairs/licensed tracks	$	2,620,000
Standardbred Fedele Fauri futurity		86,800
Standardbred Michigan futurity		86,800
Quarterhorse programs		42,600
Licensed tracks - light horse racing		82,500
Standardbred breeders' awards		1,326,400
Standardbred purses and supplements - licensed tracks		297,100
Standardbred sire stakes		1,111,300

		For Fiscal Year Ending Sept. 30, 2003
Thoroughbred sire stakes	$	1,111,300
Standardbred training and stabling		46,900
Thoroughbred program		1,944,800
Thoroughbred owners' awards		167,300
GROSS APPROPRIATION	$	8,923,800
Appropriated from:		
Special revenue funds:		
Agriculture equine industry development fund		8,923,800
State general fund/general purpose	$	0
(3) OFFICE OF RACING COMMISSIONER		
Full-time equated classified positions....36.7		
Office of racing commissioner—36.7 FTE positions	$	3,641,900
GROSS APPROPRIATION	$	3,641,900
Appropriated from:		
Special revenue funds:		
Agriculture equine industry development fund		2,341,900
State services fee fund		1,300,000
State general fund/general purpose	$	0

Capital outlay.

Sec. 103. CAPITAL OUTLAY

(1) APPROPRIATION SUMMARY		
GROSS APPROPRIATION	$	200
Total interdepartmental grants and intradepartmental transfers		0
ADJUSTED GROSS APPROPRIATION	$	200
Total federal revenues		0
Total local revenues		0
Total private revenues		0
Total other state restricted revenues		0
State general fund/general purpose	$	200
(2) STATE BUILDING AUTHORITY FINANCED CONSTRUCTION PROJECTS		
Lake Michigan College - Van Buren center, for design and construction (total authorized cost $7,800,000; state building authority share $3,899,800; Lake Michigan College share $3,900,000; state general fund share $200)	$	100
Michigan Technological University - center for integrated learning and information technology project, for design and construction (total authorized cost $33,838,700; state building authority share $24,999,800; Michigan Technological University share $8,838,700; state general fund share $200)		100
GROSS APPROPRIATION	$	200
Appropriated from:		
State general fund/general purpose	$	200

PART 1A

LINE-ITEM APPROPRIATIONS FOR
FISCAL YEAR 2001-2002

Appropriation for fiscal year ending September 30, 2002; capital outlay.

Sec. 120. There is appropriated for capital outlay and certain state departments for the fiscal year ending September 30, 2002, from the following funds:

APPROPRIATION SUMMARY:		
GROSS APPROPRIATION	$	25,444,900
Total interdepartmental grants and intradepartmental transfers		0
ADJUSTED GROSS APPROPRIATION	$	25,444,900
Total federal revenues		14,168,800
Total local revenues		0
Total private revenues		0
Total other state restricted revenues		10,971,000
State general fund/general purpose	$	305,100

Community colleges.

Sec. 121. COMMUNITY COLLEGES

(1) APPROPRIATION SUMMARY		
GROSS APPROPRIATION	$	205,100
Total interdepartmental grants and intradepartmental transfers		0
ADJUSTED GROSS APPROPRIATION	$	205,100
Total federal revenues		0
Total local revenues		0
Total private revenues		0
Total other state restricted revenues		0
State general fund/general purpose	$	205,100
(2) GRANTS		
Renaissance zone tax reimbursement funding	$	205,100
GROSS APPROPRIATION	$	205,100
Appropriated from:		
State general fund/general purpose	$	205,100

Department of community health.

Sec. 122. DEPARTMENT OF COMMUNITY HEALTH

(1) APPROPRIATION SUMMARY		
GROSS APPROPRIATION	$	25,139,800
Total interdepartmental grants and intradepartmental transfers		0
ADJUSTED GROSS APPROPRIATION	$	25,139,800
Total federal revenues		14,168,800
Total local revenues		0
Total private revenues		0
Total other state restricted revenues		10,971,000
State general fund/general purpose	$	0
(2) MEDICAL SERVICES		
Long-term care services	$	25,139,800
GROSS APPROPRIATION	$	25,139,800

		For Fiscal Year Ending Sept. 30, 2002
Appropriated from:		
Federal revenues:		
Total federal revenues	$	14,168,800
Special revenue funds:		
Medicaid quality assurance assessment		10,971,000
State general fund/general purpose	$	0

Department of history, arts, and libraries.

Sec. 123. DEPARTMENT OF HISTORY, ARTS, AND LIBRARIES

(1) APPROPRIATION SUMMARY		
GROSS APPROPRIATION	$	100,000
Total interdepartmental grants and intradepartmental transfers		0
ADJUSTED GROSS APPROPRIATION	$	100,000
Total federal revenues		0
Total local revenues		0
Total private revenues		0
Total other state restricted revenues		0
State general fund/general purpose	$	100,000
(2) LIBRARY OF MICHIGAN		
Renaissance zone reimbursement	$	100,000
Appropriated from:		
State general fund/general purpose	$	100,000

PART 2

PROVISIONS CONCERNING APPROPRIATIONS FOR FISCAL YEAR 2002-2003

GENERAL SECTIONS

Total state spending; payments to local units of government.

Sec. 201. Pursuant to section 30 of article IX of the state constitution of 1963, total state spending under part 1 for fiscal year 2002-2003 is $12,565,900.00. State payments to local units of government under part 1 are $0.

Appropriations subject to §§ 18.1101 to 18.1594.

Sec. 202. The appropriations made and the expenditures authorized under this part and the departments, agencies, commissions, boards, offices, and programs for which an appropriation is made under part 1 are subject to the management and budget act, 1984 PA 431, MCL 18.1101 to 18.1594.

DEPARTMENT OF NATURAL RESOURCES

"Old 27 North/Whitmarsh" intersection.

Sec. 301. The department shall transfer $120,000.00 from the federal recreational trail fund to the department of transportation for the purposes of completing the construction

of the separated grade crossing at "Old 27 North/Whitmarsh" intersection of the Gaylord-Cheboygan recreational trail. These funds shall be deposited into the federal funding source utilized for this project.

AERONAUTICS FUND

Airport safety and protection plan program; reimbursement of comprehensive transportation fund debt service obligations; conditional appropriation.

Sec. 401. State aeronautics funds appropriated in part 1 of House Bill No. 5651 of the 91st Legislature for airport safety and protection plan debt service are transferred to the comprehensive transportation fund and are appropriated for the purpose of reimbursing comprehensive transportation fund debt service obligations for the airport safety and protection plan program. This appropriation does not take effect unless House Bill No. 4454 of the 91st Legislature is enacted into law.

PART 2A

PROVISIONS CONCERNING APPROPRIATIONS FOR FISCAL YEAR 2001-2002

GENERAL SECTIONS

Total state spending; payments to local units of government.

Sec. 1201. Pursuant to section 30 of article IX of the state constitution of 1963, total state spending under part 1A for fiscal year 2001-2002 is $11,276,100.00. State payments to local units of government under part 1A are $305,100.00.

Appropriations and expenditures subject to §§ 18.1101 to 18.1594.

Sec. 1202. The appropriations made and the expenditures authorized under this part and the departments, agencies, commissions, boards, offices, and programs for which an appropriation is made under part 1A are subject to the management and budget act, 1984 PA 431, MCL 18.1101 to 18.1594.

Repeal of section 805 of House Bill No. 5651.

Enacting section 1. Section 805 of House Bill No. 5651 of the 91st Legislature is repealed on the effective date of this act.

This act is ordered to take immediate effect.
Approved September 30, 2002.
Filed with Secretary of State September 30, 2002.

Compiler's note: House Bill No. 4454, referred to in section 401, was filed with the Secretary of State December 30, 2002, and became P.A. 2002, No. 680, Eff. Mar. 31, 2003.

[No. 561]

(HB 5651)

AN ACT to make appropriations for the state transportation department and certain transportation purposes for the fiscal year ending September 30, 2003; to provide for the imposition of fees; to provide for reports; to create certain funds and programs; to prescribe requirements for certain railroad and bus facilities; to prescribe certain powers and duties of certain state departments and officials and local units of government; and to provide for the expenditure of the appropriations.

The People of the State of Michigan enact:

PART 1

LINE-ITEM APPROPRIATIONS

Appropriations; state transportation department.

Sec. 101. Subject to the conditions set forth in this act, the amounts listed in this part are appropriated for the state transportation department and certain state purposes designated in this act for the fiscal year ending September 30, 2003, from the funds indicated in this part. The following is a summary of the appropriations in this part:

STATE TRANSPORTATION DEPARTMENT

APPROPRIATION SUMMARY:		
Full-time equated unclassified positions	6.0	
Full-time equated classified positions	3,069.3	
GROSS APPROPRIATION		$ 3,125,181,500
Total interdepartmental grants and intradepartmental transfers		0
ADJUSTED GROSS APPROPRIATION		$ 3,125,181,500
Federal revenues:		
DOT, federal transit act		47,550,000
DOT-FHWA, highway research, planning, and construction		936,526,100
DOT-FRA, local rail service assistance		100,000
DOT-FRA, rail passenger/HSGT		3,000,000
Total federal revenues		987,176,100
Special revenue funds:		
Total local revenues		5,800,000
Total private revenues		0
Total local and private revenues		5,800,000
Michigan transportation fund		1,093,043,700
Economic development fund		57,315,000
State trunkline fund		713,370,400
State aeronautics fund		12,107,800
Comprehensive transportation fund		239,751,000
Blue Water Bridge fund		13,617,500
Intercity bus equipment fund		1,000,000
Rail preservation fund		2,000,000
Total other state restricted revenues		2,132,205,400
State general fund/general purpose		$ 0

		For Fiscal Year Ending Sept. 30, 2003
Debt service.		
Sec. 102. DEBT SERVICE		
State trunkline	$	91,903,200
Economic development		13,928,900
Critical bridge		3,000,000
Blue Water Bridge		2,308,100
Airport safety and protection plan		5,000,000
Comprehensive transportation		21,491,900
GROSS APPROPRIATION	$	137,632,100
Appropriated from:		
Federal revenues:		
DOT-FHWA, highway research, planning, and construction		21,000,000
Special revenue funds:		
Comprehensive transportation fund		21,491,900
Michigan transportation fund		3,000,000
State trunkline fund		70,903,200
Blue Water Bridge fund		2,308,100
Economic development fund		13,928,900
State aeronautics fund		5,000,000
State general fund/general purpose	$	0
Interdepartment and statutory contracts.		
Sec. 103. INTERDEPARTMENT AND STATUTORY CONTRACTS		
MTF grant to department of environmental quality	$	884,800
MTF grant to department of state for collection of revenue and fees		90,430,700
MTF grant to department of state for commemorative and specialty plates		4,069,300
MTF grant to legislative auditor general		138,000
MTF grant to department of treasury		10,225,000
STF grant to department of attorney general		2,566,200
STF grant to department of civil service		2,000,000
STF grant to department of management and budget		1,133,900
STF grant to department of state police		8,253,300
STF grant to department of treasury		29,100
STF grant to legislative auditor general		404,200
SAF grant to department of attorney general		125,400
SAF grant to department of civil service		50,000
SAF grant to department of management and budget		27,900
SAF grant to department of treasury		64,100
SAF grant to legislative auditor general		17,100
CTF grant to department of attorney general		131,500
CTF grant to department of civil service		90,000
CTF grant to department of management and budget		49,900
CTF grant to department of treasury		5,300
CTF grant to legislative auditor general		48,200
GROSS APPROPRIATION	$	120,743,900

		For Fiscal Year Ending Sept. 30, 2003
Appropriated from:		
Special revenue funds:		
Comprehensive transportation fund	$	324,900
Michigan transportation fund		105,747,800
State aeronautics fund		284,500
State trunkline fund		14,386,700
State general fund/general purpose	$	0

Executive direction.

Sec. 104. EXECUTIVE DIRECTION

Full-time equated unclassified positions 6.0		
Full-time equated classified positions 33.3		
Unclassified salaries	$	532,200
State transportation commission (per diem payments)		10,000
Commission audit—33.3 FTE positions		2,983,000
GROSS APPROPRIATION	$	3,525,200
Appropriated from:		
Special revenue funds:		
State trunkline fund		3,525,200
State general fund/general purpose	$	0

Administrative services.

Sec. 105. ADMINISTRATIVE SERVICES

Full-time equated classified positions 106.0		
Administration—66.0 FTE positions	$	5,934,700
Property management		7,237,300
Human resources—31.0 FTE positions		2,478,300
Economic development administration—9.0 FTE positions		759,500
Worker's compensation		2,966,000
GROSS APPROPRIATION	$	19,375,800
Appropriated from:		
Special revenue funds:		
Economic development fund		500,700
State aeronautics fund		657,400
Comprehensive transportation fund		1,599,000
Michigan transportation fund		77,100
State trunkline fund		16,541,600
State general fund/general purpose	$	0

Information technology.

Sec. 106. INFORMATION TECHNOLOGY

Information technology services and projects	$	26,396,400
GROSS APPROPRIATION	$	26,396,400
Appropriated from:		
Federal revenues:		
DOT-FHWA, highway research, planning, and construction		640,000
Special revenue funds:		
Blue Water Bridge fund		43,900

		For Fiscal Year Ending Sept. 30, 2003
Comprehensive transportation fund	$	240,900
Economic development fund		37,100
Michigan transportation fund		35,200
State aeronautics fund		134,500
State trunkline fund		25,264,800
State general fund/general purpose	$	0

Bureau of finance and administration.

Sec. 107. BUREAU OF FINANCE AND ADMINISTRATION

Full-time equated classified positions....237.0		
Administration—237.0 FTE positions	$	19,758,200
GROSS APPROPRIATION	$	19,758,200
Appropriated from:		
Special revenue funds:		
Michigan transportation fund		1,127,500
State trunkline fund		18,630,700
State general fund/general purpose	$	0

Bureau of transportation planning.

Sec. 108. BUREAU OF TRANSPORTATION PLANNING

Full-time equated classified positions....175.0		
Administration—175.0 FTE positions	$	22,254,900
Grants to regional planning councils		488,800
GROSS APPROPRIATION	$	22,743,700
Appropriated from:		
Federal revenues:		
DOT-FHWA, highway research, planning, and construction		14,566,800
Special revenue funds:		
State aeronautics fund		200,800
Comprehensive transportation fund		1,168,000
Michigan transportation fund		4,760,900
State trunkline fund		2,047,200
State general fund/general purpose	$	0

Bureau of highways.

Sec. 109. BUREAU OF HIGHWAYS

Full-time equated classified positions....1,625.4		
Engineering operations—799.4 FTE positions	$	31,796,800
Maintenance operations—78.0 FTE positions		7,071,200
Program services—748.0 FTE positions		39,004,800
GROSS APPROPRIATION	$	77,872,800
Appropriated from:		
Federal revenues:		
DOT-FHWA, highway research, planning, and construction		5,000,000
Special revenue funds:		
Michigan transportation fund		4,155,900
State trunkline fund		68,716,900
State general fund/general purpose	$	0

		For Fiscal Year Ending Sept. 30, 2003
Highway maintenance.		
Sec. 110. HIGHWAY MAINTENANCE		
Full-time equated classified positions....699.6		
State trunkline operations—699.6 FTE positions	$	99,057,900
Contract operations		133,853,200
GROSS APPROPRIATION	$	232,911,100
Appropriated from:		
Special revenue funds:		
State trunkline fund		232,911,100
State general fund/general purpose	$	0
Road and bridge programs.		
Sec. 111. ROAD AND BRIDGE PROGRAMS		
State trunkline federal aid and road and bridge construction	$	921,880,300
Local federal aid and road and bridge construction		215,132,000
Grants to local programs		33,000,000
Rail grade crossing		3,000,000
Critical bridge fund		29,750,000
County road commissions		597,971,700
Cities and villages		333,396,100
GROSS APPROPRIATION	$	2,134,130,100
Appropriated from:		
Federal revenues:		
DOT-FHWA, highway research, planning, and construction		895,319,300
Special revenue funds:		
Local funds		5,000,000
Blue Water Bridge fund		1,000,000
Michigan transportation fund		972,367,800
State trunkline fund		260,443,000
State general fund/general purpose	$	0
Blue water bridge.		
Sec. 112. BLUE WATER BRIDGE		
Full-time equated classified positions....33.0		
Blue Water Bridge operations—33.0 FTE positions	$	10,265,500
GROSS APPROPRIATION	$	10,265,500
Appropriated from:		
Special revenue funds:		
Blue Water Bridge fund		10,265,500
State general fund/general purpose	$	0
Transportation economic development fund.		
Sec. 113. TRANSPORTATION ECONOMIC DEVELOPMENT FUND		
Forest roads	$	5,040,000
Rural county urban system		2,500,000
Target industries/economic redevelopment		19,404,300
Urban county congestion		7,952,000

		For Fiscal Year Ending Sept. 30, 2003
Rural county primary	$	7,952,000
GROSS APPROPRIATION	$	42,848,300
Appropriated from:		
Special revenue funds:		
Economic development fund	$	42,848,300
State general fund/general purpose	$	0

Bureau of aeronautics.

Sec. 114. BUREAU OF AERONAUTICS

Full-time equated classified positions	56.0	
Administration—56.0 FTE positions	$	5,530,600
Air service program		300,000
GROSS APPROPRIATION	$	5,830,600
Appropriated from:		
Special revenue funds:		
State aeronautics fund		5,830,600
State general fund/general purpose	$	0

Bureau of urban and public transportation.

Sec. 115. BUREAU OF URBAN AND PUBLIC TRANSPORTATION

Full-time equated classified positions	104.0	
Administration—104.0 FTE positions	$	8,725,400
GROSS APPROPRIATION	$	8,725,400
Appropriated from:		
Special revenue funds:		
Comprehensive transportation fund		6,953,900
Michigan transportation fund		1,771,500
State general fund/general purpose	$	0

Bus transit division: statutory operating.

Sec. 116. BUS TRANSIT DIVISION: STATUTORY OPERATING

Local bus operating	$	160,000,000
Nonurban operating/capital		10,300,000
GROSS APPROPRIATION	$	170,300,000
Appropriated from:		
Federal revenues:		
DOT, federal transit act		10,100,000
Special revenue funds:		
Comprehensive transportation fund		160,000,000
Local funds		200,000
State general fund/general purpose	$	0

Intercity passenger and freight.

Sec. 117. INTERCITY PASSENGER AND FREIGHT

Freight property management	$	1,500,000
Detroit/Wayne County port authority		500,000
Intercity bus equipment		3,000,000
Rail passenger service		11,300,000

		For Fiscal Year Ending Sept. 30, 2003
Freight preservation and development	$	5,692,900
Rail infrastructure loan program		100,000
Intercity bus service development		2,850,000
Marine passenger service		800,000
Terminal development		2,884,800
GROSS APPROPRIATION	$	28,627,700
Appropriated from:		
Federal revenues:		
DOT, federal transit act		1,500,000
DOT-FRA, local rail service assistance		100,000
DOT-FRA, rail passenger/HSGT		3,000,000
Special revenue funds:		
Rail preservation fund		2,000,000
Intercity bus equipment fund		1,000,000
Comprehensive transportation fund		20,977,700
Local funds		50,000
State general fund/general purpose	$	0

Public transportation development.

Sec. 118. PUBLIC TRANSPORTATION DEVELOPMENT

Specialized services	$	3,939,500
Municipal credit program		2,000,000
Bus capital		48,849,500
Ride sharing		330,700
Van pooling		195,000
Bus property management		50,000
Service development and new technology		1,550,000
Planning grants		80,000
Audit settlements		150,000
Regional service coordination		500,000
Work first initiative		5,850,000
GROSS APPROPRIATION	$	63,494,700
Appropriated from:		
Federal revenues:		
DOT, federal transit act		35,950,000
Special revenue funds:		
Comprehensive transportation fund		26,994,700
Local funds		550,000
State general fund/general purpose	$	0

PART 2

PROVISIONS CONCERNING APPROPRIATIONS

GENERAL SECTIONS

Total state spending; payments to local units of government.

Sec. 201. Pursuant to section 30 of article IX of the state constitution of 1963, total state spending from state resources under part 1 for fiscal year 2002-2003 is $2,132,205,400.00