ADDENDUM 1

This Addendum is attached to and made a part of the Plan of Operation of the Governing Board of the Medicare Supplement "Under 50" Program approved by the Department of Banking and Insurance on November 26, 1996.

ADMINISTRATIVE GUIDELINES FOR PROGRAM ENROLLMENT

as of 6/2002

Guarantee Issue	The Under 50 Plan shall not deny or condition the issuance or renewal, nor discriminate in the pricing of coverage because of the health status, claims experience, receipt of health care or medical condition of an applicant in the following situations:
Situation 1:	An individual becomes eligible for benefits under Medicare Part B.
Time Frame	*The application must be submitted during the six-month period beginning with the first month in which the individual is enrolled for benefits under Medicare Part B if the individual became eligible for Medicare prior to January 1, 2020. The application must be submitted during the 12-month period beginning with the first month in which the individual is enrolled for benefits under Medicare Part B if the individual becomes eligible for Medicare on or after January 1, 2020.*
Situation 2:	Retroactive determination of Medicare eligibility
Timeframe	*The application must be submitted during the six-month period beginning with the month in which the determination is made if Medicare eligibility occurred prior to January 1, 2020; otherwise, the application must be submitted during the 12-month period beginning with the month in which the determination is made.*
Situation 3:	The individual is no longer eligible under a plan that is considered Creditable Coverage or the plan terminates or ceases to provide benefits.
Timeframe	*The application must be submitted within 63 days of the applicant losing Creditable Coverage.*
Situation 4:	The individual was enrolled under an employee welfare benefit plan that: • provided health benefits that supplement Medicare benefits and that plan terminates or ceases to provide all Medicare supplemental health benefits, or • is primary or secondary to Medicare and the plan terminates, ceases to provide all health benefits to the individual, or the individual leaves the plan.
Timeframe	*The application must be submitted within 63 days from the date the individual receives a notice of termination, or claim denial due to the termination or within 63 days after the health coverage ends.*
Situation 5:	The individual elects COBRA coverage and one of the following occurs: • the individual chooses to terminate their COBRA coverage before the maximum coverage period is reached; or

	• The COBRA coverage period is exhausted.
Timeframe	*The application must be submitted within 63 days of the date COBRA coverage terminated.*

Situation 6:	The individual meets both of the following requirements: • Is enrolled in one of the following plans: ❖ A Medicare + Choice plan, ❖ A Medicare managed care plan, ❖ A Medicare private-fee-for-services plan, ❖ A Medicare risk or cost contract, ❖ A similar organization operating under a demonstration project authority, ❖ A health care prepayment plan, or ❖ A Medicare SELECT plan; and • Enrollment ends because: ❖ The organization's or plan's certification under Part C of Medicare has been terminated or will be terminated, ❖ The plan is leaving the Medicare program, ❖ The organization has discontinued providing the plan or will be discontinuing the plan in the area where the enrollee resides, ❖ The demonstration project has ended, ❖ The enrollee moves out of the service area, ❖ The individual demonstrates that the organization substantially violated a material provision of the policy (with respect to the individual), such as failure to provide covered care on a time basis or adhere to quality standards, or ❖ The organization, agent or other entity acting on the organization's behalf materially misrepresented the policy provisions in marketing.
Timeframe	*The application must be submitted:* • *<u>For involuntary termination</u>, during the period **beginning** on the date the individual receives a notice of termination and **ending** 63 days after the date their coverage is terminated.* • *<u>For an voluntary terminations</u>, during the period **beginning** 60 days before the disenrollment effective date and **ending** 63 days after the disenrollment effective date.*
Situation 7:	The individual is enrolled under a Medicare Supplement policy and the enrollment ceases because of the bankruptcy or insolvency of the issuer or other involuntary termination of coverage under the policy.
Timeframe	*The application must be submitted during the period **beginning** on the earlier of either:* • *The date the individual receives a notice of termination, bankruptcy or insolvency or other such similar notice, if any, or*

	• *The date their prior coverage terminated* *And **ending** ~~6~~63 days after their prior coverage is terminated.*

Situation 8:	The individual is enrolled under a Medicare Supplemental policy and enrollment ends because: • The issuer substantially violated a material provision of the policy; or • The issuer, agent or other entity acting on the issuer's behalf, materially represented the policy provisions in marketing the policy.
Timeframe	*The application must be submitted during the period **beginning** on the disenrollment effective date and **ending** 63 days after the disenrollment effective date. **Note:** If the termination is voluntary, the period begins 60 days before the disenrollment effective date and **ends** 63 days after the disenrollment effective dates.*
Situation 9:	The individual meets all of the following requirements: • Is enrolled under a Medicare supplement policy, including the Under 50 plan, and terminates enrollment; and • Subsequently enrolls, for the first time, under one of the following plans: ❖ A Medicare + Choice plan ❖ A Medicare managed care plan, ❖ A Medicare private-fee-for-services plan, ❖ A Medicare risk or cost contract, ❖ A similar organization operating under a demonstration project authority, ❖ A health care prepayment plan, or ❖ A Medicare SELECT plan; then • Terminates their enrollment within the trial period. The trial period is whichever of the following that occurs first: • 12 months of continuous enrollment in any one plan of the types listed above; or • 24 months of continuous enrollment in any 2 or more plans of the types listed above.
Timeframe	*The application must be submitted during the period **beginning** 60 days before the disenrollment effective date and **ending** 63 days after the disenrollment effective date.*
Situation 10:	Other situations as the Board deems appropriate to meet the objectives of the Program in a fair and equitable manner.
Timeframe	*To be determined.*
Effective date	Under all situations, the effective date of coverage is the first day of the month following the date the applicant enrolls in the Program and makes premium payment.

Pre-existing condition limitation	Except as described below, benefits will not be provided for a pre-existing condition until a person has been covered under the Medigap plan for three (3) months. A pre-existing condition is a condition for which medical advice was given or for which treatment was recommended or given by a physician during the six (6) months before the effective date of the Medigap plan. The pre-existing condition limitation: • Will not apply to individuals who submit an application during the time period referenced in situations 4, 6, 7, 8 or 9 above. • Will be reduced by the amount of time the applicant had a continuous period of Creditable Coverage, if he or she submits an application during the time periods referenced in the other situations.
Creditable coverage	Creditable coverage includes coverage of an individual under any of the following: ❖ A group health plan (including a self-funded plan); ❖ Health insurance coverage; ❖ Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928; ❖ Chapter 55 of Title 10 United States Code (CHAMPUS); ❖ A medical care program of the Indian health Service or of a tribal organization; ❖ A State health benefits risk pool; ❖ A health plan offered under chapter 89 of Title 5 United States Code (A Federal Employees Health Benefits Program); ❖ A public health plan as defined in federal regulation; and ❖ A health benefits plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)). **Note:** Medicare supplement (Medigap) coverage <u>is not</u> considered creditable coverage.
What creditable coverage does not include	Creditable coverage shall not include one or more, or any combination of the following: ❖ Coverage only for accident or disability income insurance, or any combination thereof; ❖ Coverage issued as a supplement to liability insurance; ❖ Liability insurance, including general liability insurance and automobile liability insurance; ❖ Workers' compensation or similar insurance; ❖ Automobile medical payment insurance; ❖ Credit-only insurance;

	❖ Coverage for on-site medical clinics; ❖ Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental; to other insurance benefits; ❖ Limited scope dental or vision benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan; ❖ Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof if they are provided under a separate policy, certificate or contract of insurance or are not otherwise an integral part of the plan; ❖ Such other similar, limited benefits as are specified in federal regulations if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan; ❖ Coverage only for a specified disease or illness if offered as independent, non-coordinated benefits; ❖ Hospital indemnity or other fixed indemnity insurance if offered as independent, non-coordinated benefits; ❖ Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act if it is offered as a separate policy, certificate or contract of insurance; ❖ Coverage supplemental to the coverage provided under Chapter 55 of Title 10, Untied States Code if it is offered as a separate policy, certificate or contract of insurance; and ❖ Similar supplemental coverage provided to coverage under a group health plan if it is offered as a separate policy, certificate or contract of insurance.