

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

500.3815 Outline of coverage; acknowledgment of receipt; compliance with notice requirements; substitute; language, written or electronic format, and required items.

Sec. 3815.

(1) An insurer that offers a Medicare supplement policy shall provide to the applicant at the time of application an outline of coverage in written or electronic format and, except for direct response solicitation policies, shall obtain an acknowledgment of receipt of the outline of coverage from the applicant in written or electronic format. The outline of coverage provided to applicants under this section must consist of the following 4 parts:

- (a) A cover page.
- (b) Premium information.
- (c) Disclosure pages.
- (d) Charts displaying the features of each benefit plan offered by the insurer.

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

(3) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and must contain the following statement, in not 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 on application and the coverage
 originally applied for has not been issued.

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

BENEFIT CHART OF MEDICARE SUPPLEMENT PLANS SOLD
ON OR AFTER JUNE 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Plans E, H, I, and J are no longer available for sale. (This sentence must not appear after June 1, 2011.)

BASIC BENEFITS:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.

Blood: First three pints of blood each year.

Hospice: Part A coinsurance

A	B	C**	D	F F* **	G/G*
Basic, including	Basic, including	Basic, including	Basic, including	Basic, including	Basic, including
100% Part	100% Part	100% Part	100% Part	100% Part	100% Part

B coin- surance	B coinsur- ance	B coinsur- ance	B coinsur- ance	B coinsur- ance	B coinsur- ance
 	 	Skilled Nursing Facility Coinsur- ance	Skilled Nursing Facility Coinsur- ance	Skilled Nursing Facility Coinsur- ance	Skilled Nursing Facility Coinsur- ance
 	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
 	 	Part B Deductible	 	Part B Deductible	
 	 	 	 	Part B Excess (100%)	Part B Excess (100%)
 	 	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50% 	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75% 	Basic, including 100% Part B coinsurance 	Basic, includ- ing 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copay- ment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
 	 	 	
 	 	 	
 	 	Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit \$5,240; paid at 100% after limit reached	Out-of-pocket limit \$2,620; paid at 100% after limit reached	 	

* Plans F and G also have options called high-deductible Plan F and high-deductible Plan G. These high-deductible plans pay the same benefits as Plan F or Plan G, as applicable, after one has paid a calendar year \$2,240 deductible. Benefits from high-deductible Plan F or high-deductible Plan G will not begin until out-of-pocket

expenses exceed \$2,240. Out-of-pocket expenses for these deductibles are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

** Plan C, Plan F, and high-deductible Plan F are only available to individuals eligible for Medicare before January 1, 2020.

 PREMIUM INFORMATION

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

 DISCLOSURES

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

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates before June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. (This sentence must not appear after June 1, 2011.)

 READ YOUR POLICY VERY CAREFULLY

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

 RIGHT TO RETURN POLICY

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

 POLICY REPLACEMENT

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

 NOTICE

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

[For agent issued policies]

Neither (insert insurer's name) nor its agents are connected with Medicare.

[For direct response issued policies]

(Insert insurer's name) is not connected with Medicare.

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

 COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

[Include for each plan offered by the insurer a chart showing the services, Medicare payments, plan payments, and insured payments using the same language, in the same order, and using uniform layout and format as shown in the charts that follow. An insurer may use additional benefit plan designations on these charts under section 3809(1)(k). Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the director. The insurer issuing the policy shall change the dollar amounts each year to reflect current figures. No more than 4 plans may be shown on 1 chart.] Charts for each plan are as follows:

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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HOSPITALIZATION*	 	 	
Semiprivate room and	 	 	
board, general nursing	 	 	
and miscellaneous	 	 	
services and supplies	 	 	
First 60 days	All but	\$0	\$1,340
 	\$1,340	 	(Part A
 	 	 	Deductible)
61st thru 90th day	All but	\$335	\$0
 	\$335 a day	a day	
91st day and after:	 	 	
-While using 60	 	 	
lifetime reserve days	All but	\$670	\$0
 	\$670 a day	a day	
-Once lifetime reserve	 	 	
days are used:	 	 	
-Additional 365 days	\$0	100% of	\$0**
 	 	Medicare	
 	 	Eligible	
 	 	Expenses	
-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	\$0	Up to
 	\$167.50 a day	 	\$167.50 a day
101st day and after	\$0	\$0	All costs
BLOOD	 	 	
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE	 	 	
You must meet	All but very	 	\$0
Medicare's requirements	limited	Medicare	
including a doctor's	copayment/	copayment/	
certification of terminal	coinsurance	coinsurance	
illness	for outpatient	 	
 	drugs and	 	

 	inpatient	 	
 	respite care	 	
 	 	 	

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

PLAN A

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

***Once you have been billed \$183 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 \$183 of	 	 	
Medicare Approved	\$0	\$0	\$183
Amounts*	 	 	(Part B
 	 	 	Deductible)
Remainder of Medicare	 	 	
Approved Amounts	80%	20%	\$0
Part B Excess Charges	 	 	
(Above Medicare	 	 	
Approved Amounts)	\$0	\$0	All Costs
BLOOD	 	 	
First 3 pints	\$0	All Costs	\$0
Next \$183 of	 	 	
Medicare	\$0	\$0	\$183
Approved Amounts*	 	 	(Part B
 	 	 	Deductible)
Remainder of Medicare	 	 	
Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY	 	 	
SERVICES–	 	 	
Tests for	 	 	
diagnostic services	100%	\$0	\$0

HOME HEALTH CARE	 	 	
Medicare Approved	 	 	
Services	 	 	
–Medically necessary	 	 	
skilled care services	 	 	
and medical supplies	100%	\$0	\$0
–Durable medical	 	 	
equipment	 	 	
First \$183 of	 	 	
Medicare	\$0	\$0	\$183
Approved Amounts*	 	 	(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	\$1,340	\$0
 	\$1,340	(Part A	
 	 	Deductible)	
61st thru 90th day	All but	\$335	\$0
 	\$335 a day	a day	
91st day and after	 	 	
–While using 60	 	 	
lifetime reserve days	All but	\$670	\$0
 	\$670 a day	a day	
–Once lifetime reserve	 	 	
days are used:	 	 	
–Additional 365 days	\$0	100% of	\$0**
 	 	Medicare	
 	 	Eligible	
 	 	Expenses	
–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	\$0	Up to
 	\$167.50 a day	 	\$167.50 a day
101st day and after	\$0	\$0	All costs
BLOOD	 	 	
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE	 	 	
 	All but very	 	
 	limited	Medicare	\$0
 	copayment/	copayment/	
 	coinsurance	coinsurance	
You must meet	for outpatient	 	
Medicare's requirements,	drugs and	 	
including a doctor's	inpatient	 	
certification of	respite care	 	
terminal illness	 	 	

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

PLAN B

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

***Once you have been billed \$183 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,	 	 	
Medicare-Approved	\$0160;	\$0160;	\$180;

Amounts*	 	 	(Part B
 	 	 	Deductible)
Remainder of Medicare	 	 	
Approved Amounts	80%	20%	\$0
Part B Excess Charges	 	 	
(Above Medicare	 	 	
Approved Amounts)	\$0	\$0	All Costs
BLOOD	 	 	
First 3 pints	\$0	All Costs	\$0
Next \$183 of Medicare	 	 	
Approved Amounts*	\$0	\$0	\$183
 	 	 	(Part B
Remainder of Medicare	 	 	Deductible)
Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY	 	 	
SERVICES—	 	 	
Tests for	 	 	
diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE	 	 	
Medicare Approved	 	 	
Services	 	 	
—Medically necessary	 	 	
skilled care services	 	 	
and medical supplies	100%	\$0	\$0
—Durable medical	 	 	
equipment	 	 	
First \$183 of	 	 	
Medicare	 	 	
Approved Amounts*	\$0	\$0	\$183
 	 	 	(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	\$1,340	\$0
 	\$1,340	(Part A	
 	 	Deductible)	
61st thru 90th day	All but	\$335	\$0
 	\$335 a day	a day	
91st day and after	 	 	
-While using 60	 	 	
lifetime reserve days	All but	\$670	\$0
 	\$670 a day	a day	
-Once lifetime reserve	 	 	
days are used:	 	 	
-Additional 365 days	\$0	100% of	\$0**
 	 	Medicare	
 	 	Eligible	
 	 	Expenses	
-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	Up to	\$0
 	\$167.50 a day	\$167.50 a day	
101st day and after	\$0	\$0	All costs
BLOOD	 	 	
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE	 	 	
 	All but very	 	\$0
 	limited	Medicare	
 	copayment/	copayment/	
 	coinsurance	coinsurance	
You must meet	for outpatient	 	
Medicare's requirements,	drugs and	 	
including a doctor's	inpatient	 	
certification of	respite care	 	
terminal illness	 	 	

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in

the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C

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

*Once you have been billed \$183 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 \$183 of	 	 	
Medicare Approved	\$0	\$183	\$0
Amounts*	 	(Part B	
 	 	Deductible)	
Remainder of Medicare	 	 	
Approved Amounts	80%	20%	\$0
Part B Excess Charges	 	 	
(Above Medicare	 	 	
Approved Amounts)	\$0	\$0	All Costs
BLOOD	 	 	
First 3 pints	\$0	All Costs	\$0
Next \$183 of Medicare	 	 	
Approved Amounts*	\$0	\$183	\$0
 	 	(Part B	
 	 	Deductible)	
Remainder of Medicare	 	 	
Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY	 	 	
SERVICES—	 	 	
Tests for	 	 	
diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE	 	 	
Medicare Approved	 	 	
Services	 	 	
—Medically necessary	 	 	

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

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 \$183 of	 	 	
Medicare Approved	\$0	\$0	\$183
Amounts*	 	 	(Part B
 	 	 	Deductible)
Remainder of Medicare	 	 	
Approved Amounts	80%	20%	\$0
Part B Excess Charges	 	 	
(Above Medicare	 	 	
Approved Amounts)	\$0	\$0	All Costs
BLOOD	 	 	
First 3 pints	\$0	All Costs	\$0
Next \$183 of Medicare	 	 	
Approved Amounts*	\$0	\$0	\$183
 	 	 	(Part B
 	 	 	Deductible)
Remainder of Medicare	 	 	
Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY	 	 	
SERVICES--	 	 	
Tests for	 	 	
diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE	 	 	
Medicare Approved	 	 	
Services	 	 	
-Medically necessary	 	 	
skilled care services	 	 	
and medical supplies	100%	\$0	\$0
-Durable medical	 	 	
equipment	 	 	
First \$183 of	 	 	
Medicare Approved	\$0	\$0	\$183
Amounts*	 	 	(Part B
 	 	 	Deductible)
Remainder of Medicare	 	 	

Approved Amounts	80%	20%	\$0
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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	20% and
 	 	lifetime	amounts
 	 	maximum	over the
 	 	benefit	\$50,000
 	 	of \$50,000	lifetime
 	 	 	maximum

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 benefits as plan F after you have paid a calendar year \$2,240 deductible. Benefits from the high-deductible plan F will not begin until out-of-pocket expenses are \$2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes Medicare deductibles for part A and part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY	IN ADDITION TO
 	 	\$2,240	\$2,240
 	 	DEDUCTIBLE**,	DEDUCTIBLE**,
 	 	PLAN PAYS	YOU PAY
HOSPITALIZATION*	 	 	
Semiprivate room and	 	 	
board, general nursing	 	 	
and miscellaneous	 	 	
services and supplies	 	 	
First 60 days	All but	\$1,340	\$0
 	\$1,340	(Part A	
 	 	Deductible)	
61st thru 90th day	All but	\$335	\$0
 	\$335 a day	a day	
91st day and after	 	 	
—While using 60	 	 	
lifetime reserve days	All but	\$670	\$0
 	\$670 a day	a day	
—Once lifetime reserve	 	 	
days are used:	 	 	

-Additional 365 days	\$0	100% of	\$0***
 	 	Medicare	
 	 	Eligible	
 	 	Expenses	
-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	Up to	\$0
 	\$167.50 a day	\$167.50 a day	
101st day and after	\$0	\$0	All costs
BLOOD	 	 	
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE	 	 	
 	All but very	Medicare	\$0
 	limited	copayment/	
 	copayment/	coinsurance	
 	coinsurance	 	
You must	for	 	
meet Medicare's	outpatient	 	
requirements, including	drugs and	 	
a doctor's certification	inpatient	 	
of terminal illness	respite care	 	

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

PLAN F

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

*Once you have been billed \$183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

**This high-deductible plan pays the same benefits as plan F after you have paid a calendar year \$2,240 deductible. Benefits from the high-deductible plan F will not begin until out-of-pocket expenses are \$2,240. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes Medicare deductibles for part A and part B, but does not include the plan's separate foreign travel emergency deductible.

 	PAYS	PAY	TO
 	 	\$2,240	\$2,240
 	 	DEDUCTIBLE**,	DEDUCTIBLE**,
 	 	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 \$183 of	 	 	
Medicare Approved	\$0	\$183	\$0
Amounts*	 	(Part B	
 	 	Deductible)	
Remainder of Medicare	 	 	
Approved Amounts	80%	20%	\$0
Part B Excess Charges	 	 	
(Above Medicare	 	 	
Approved Amounts)	\$0	100%	\$0
BLOOD	 	 	
First 3 pints	\$0	All Costs	\$0
Next \$183 of	 	 	
Medicare Approved	\$0	\$183	\$0
Amounts*	 	(Part B	
 	 	Deductible)	
Remainder of Medicare	 	 	
Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY	 	 	
SERVICES—	 	 	
Tests for	 	 	
diagnostic services	100%	\$0	\$0

PARTS A & B

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

First \$183 of	 	 	
Medicare Approved	\$0	\$183	\$0
Amounts*	 	(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	20% and
 	 	lifetime	amounts
 	 	maximum	over the
 	 	benefit	\$50,000
 	 	of \$50,000	lifetime
 	 	 	maximum

PLAN G OR HIGH-DEDUCTIBLE 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.

** This high-deductible plan pays the same benefits as Plan G after one has paid a calendar year \$2,240 deductible. Benefits from the high-deductible Plan G will not begin until out-of-pocket expenses are \$2,240. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY	IN ADDITION TO
 	 	\$2,240	\$2,240
 	 	DEDUCTIBLE**,	DEDUCTIBLE**,
 	 	PLAN PAYS	YOU PAY
HOSPITALIZATION*	 	 	
Semiprivate room and	 	 	
board, general nursing	 	 	
and miscellaneous	 	 	
services and supplies	 	 	
First 60 days	All but	\$1,340	\$0
 	\$1,340	(Part A	
 	 	Deductible)	
61st thru 90th day	All but	\$335	\$0
 	\$335 a day	a day	

91st day and after	 	 	
-While using 60	 	 	
lifetime reserve days	All but	\$670	\$0
 	\$670 a day	a day	
-Once lifetime reserve	 	 	
days are used:	 	 	
-Additional 365 days	\$0	100% of	\$0***
 	 	Medicare	
 	 	Eligible	
 	 	Expenses	
-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	Up to	\$0
 	\$167.50 a day	\$167.50 a day	
101st day and after	\$0	\$0	All costs
BLOOD	 	 	
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE	 	 	
 	All but very	 	\$0
 	limited	Medicare	
 	copayment/	copayment/	
 	coinsurance	coinsurance	
You must meet	for outpatient	 	
Medicare's requirements,	drugs and	 	
including a doctor's	inpatient	 	
certification of	respite care	 	
terminal illness	 	 	

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

PLAN G OR HIGH-DEDUCTIBLE PLAN G

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

*Once you have been billed \$183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

**** This high-deductible plan pays the same benefits as Plan G after one has paid a calendar year \$2,240 deductible. Benefits from the high-deductible Plan G will not begin until out-of-pocket expenses are \$2,240. Out-of-pocket expenses for this deductible include expenses for the Medicare part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY	IN ADDITION TO
 	 	\$2,240	\$2,240
 	 	DEDUCTIBLE**,	DEDUCTIBLE**,
 	 	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 \$183 of	 	 	
Medicare Approved	\$0	\$0	\$163
Amounts*	 	 	(Unless
 	 	 	Part B
 	 	 	Deductible
 	 	 	has been
 	 	 	met)
Remainder of Medicare	 	 	
Approved Amounts	80%	20%	\$0
Part B Excess Charges	 	 	
(Above Medicare	 	 	
Approved Amounts)	\$0	100%	0%
BLOOD	 	 	
First 3 pints	\$0	All Costs	\$0
Next \$183 of	 	 	
Medicare Approved	\$0	\$0	\$183
Amounts*	 	 	(Unless
 	 	 	Part B
 	 	 	Deductible
 	 	 	has been
 	 	 	met)
Remainder of Medicare	 	 	
Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY	 	 	
SERVICES—	 	 	
Tests for	 	 	

diagnostic services	100%	\$0	\$0
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PARTS A & B

HOME HEALTH CARE	 	 	
Medicare Approved	 	 	
Services	 	 	
-Medically necessary	 	 	
skilled care services	 	 	
and medical supplies	100%	\$0	\$0
-Durable medical	 	 	
equipment	 	 	
First \$183 of	 	 	
Medicare Approved	\$0	\$0	\$183
Amounts*	 	 	(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	20% and
 	 	lifetime	amounts
 	 	maximum	over the
 	 	benefit	\$50,000
 	 	of \$50,000	lifetime
 	 	 	maximum

PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$5,240 each calendar year. The amounts that count toward your annual limit are noted with diamonds 1 in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
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HOSPITALIZATION**	 	 	
Semiprivate room and	 	 	
board, general nursing	 	 	
and miscellaneous	 	 	
services and supplies	 	 	
First 60 days	All but	\$670	\$670
 	\$1,340	(50%	(50% of
 	 	of Part A	Part A
 	 	Deducti-	Deductible) 1
 	 	ble)	
 	 	 	
61st thru 90th day	All but	\$335	\$0
 	\$335 a day	a day	
91st day and after:	 	 	
-While using 60	 	 	
lifetime reserve days	All but	\$670	\$0
 	\$670 a day	a day	
-Once lifetime reserve	 	 	
days are used:	 	 	
-Additional 365 days	\$0	100% of	\$0***
 	 	Medicare	
 	 	Eligible	
 	 	Expenses	
-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	Up to	Up to
 	\$167.50 a	\$83.75	\$83.75
 	day	a day	a day 1
101st day and after	\$0	\$0	All costs
BLOOD	 	 	
First 3 pints	\$0	50%	50% 1
Additional amounts	100%	\$0	\$0
HOSPICE CARE	 	 	
 	 	50% of	50% of
 	 	copayment/	Medicare

 	 	coinsur-	copayment/
 	 	ance	coinsurance 1
You must meet	 	 	
Medicare's requirements,	 	 	
including a doctor's	 	 	
certification of terminal	 	 	
illness	All but very	 	
 	limited	 	
 	copayment/	 	
 	coinsurance for	 	
 	outpatient	 	
 	drugs and	 	
 	inpatient	 	
 	respite care	 	

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

PLAN K

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

****Once you have been billed \$183 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 \$183 of	 	 	
Medicare Approved	\$0	\$0	\$183
Amounts****	 	 	(Part B
 	 	 	Deductible)
 	 	 	**** 1
 	 	 	
Preventive Benefits for	Generally 75%	Remainder	All costs
Medicare covered	or more of	of Medi-	above Medi-
services	Medicare ap-	care	care
 	proved amounts	approved	approved
 	 	amounts	amounts
Remainder of Medicare	Generally 80%	Generally	Generally

Approved Amounts	 	10%	10% 1
 	 	 	
Part B Excess Charges	\$0	\$0	All costs
(Above Medicare	 	 	(and they do
Approved Amounts)	 	 	not count
 	 	 	toward
 	 	 	annual out-
 	 	 	of-pocket
 	 	 	limit of
 	 	 	\$5,240) *
BLOOD	 	 	
First 3 pints	\$0	50%	50% 1
Next \$183 of	 	 	
Medicare Approved	\$0	\$0	\$183
Amounts****	 	 	(Part B
 	 	 	Deductible)
 	 	 	**** 1
Remainder of Medicare	Generally 80%	Generally	Generally
Approved Amounts	 	10%	10% 1
CLINICAL LABORATORY	 	 	
SERVICES-Tests for	 	 	
diagnostic services	100%	\$0	\$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$5,240 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PARTS A & B

HOME HEALTH CARE	 	 	
Medicare Approved	 	 	
Services	 	 	
-Medically necessary	 	 	
skilled care services	 	 	
and medical supplies	100%	\$0	\$0
-Durable medical	 	 	
equipment	 	 	
First \$183 of	 	 	
Medicare Approved	\$0	\$0	\$183
Amounts*****	 	 	(Part B
 	 	 	Deductible) 1
Remainder of Medicare	 	 	
Approved Amounts	80%	10%	10% 1

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

PLAN L

*You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2,620 each calendar year. The amounts that count toward your annual limit are noted with diamonds 1 in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance

for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN L

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**	 	 	
Semiprivate room and	 	 	
board, general nursing	 	 	
and miscellaneous	 	 	
services and supplies	 	 	
First 60 days	All but	\$1,005	\$335
 	\$1,340	(75% of	(25% of
 	 	Part A	Part A
 	 	Deducti-	Deductible) 1
 	 	ble)	
61st thru 90th day	All but	\$335	\$0
 	\$335 a day	a day	
91st day and after:	 	 	
-While using 60	 	 	
lifetime reserve days	All but	\$670	\$0
 	\$670 a day	a day	
-Once lifetime reserve	 	 	
days are used:	 	 	
-Additional 365 days	\$0	100% of	\$0***
 	 	Medicare	
 	 	Eligible	
 	 	Expenses	
-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	Up to	Up to
 	\$167.50 a	\$125.63	\$41.88
 	day	a day	a day 1

101st day and after	\$0	\$0	All costs
BLOOD	 	 	
First 3 pints	\$0	75%	25% 1
Additional amounts	100%	\$0	\$0
HOSPICE CARE	 	 	
 	 	75% of	25% of
 	 	copayment/	copayment/
 	 	coinsur-	coinsurance 1
 	 	ance	
You must meet	 	 	
Medicare's requirements,	 	 	
including a doctor's	 	 	
certification of terminal	All	 	
illness	but very	 	
 	limited copay-	 	
 	ment/coinsur-	 	
 	ance for	 	
 	outpatient	 	
 	drugs and	 	
 	inpatient	 	
 	respite care	 	

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

PLAN L

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

****Once you have been billed \$183 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 \$183 of	 	 	
Medicare Approved	\$0	\$0	\$183
Amounts****	 	 	(Part
 	 	 	B Deducti-
 	 	 	ble)**** 1

Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	Generally 75% or more of Medicare approved amounts Generally 80%	Remainder of Medicare approved amounts Generally 15%	All costs above Medicare approved amounts Generally 5% 1
 Part B Excess Charges (Above Medicare Approved Amounts) 	 \$0 	 \$0 	 All costs (and they do not count toward annual out-of-pocket limit of \$2,620) *
BLOOD First 3 pints Next \$183 of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	 \$0 \$0 Generally 80%	 75% \$0 Generally 15%	 25% 1 \$183 (Part B Deductible) 1 Generally 5% 1
CLINICAL LABORATORY SERVICES—Tests for diagnostic services	 100%	 \$0	 \$0

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$2,620 per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PARTS A & B

HOME HEALTH CARE Medicare Approved Services —Medically necessary skilled care services and medical supplies —Durable medical equipment First \$183 of Medicare Approved Amounts***** Remainder of Medicare Approved Amounts	 100% \$0 80%	 \$0 \$0 15%	 \$0 \$183 (Part B Deductible) 1 5% 1
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*****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

PLAN M

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 \$1,340	\$670 (50%	\$670 (50%
 	 	of Part A	of Part A
 	 	Deduc-	Deduc-
 	 	tible)	tible)
61st thru 90th day	All but \$335	\$335	\$0
 	a day	a day	
91st day and after:	 	 	
-While using 60	 	 	
lifetime reserve days	All but \$670	\$670	\$0
 	a day	a day	
-Once lifetime reserve	 	 	
days are used:	 	 	
-Additional 365 days	\$0	100% of	\$0**
 	 	Medicare	
 	 	Eligible	
 	 	Expenses	
-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	\$0	\$0
 	amounts	 	
21st thru 100th day	All but \$167.50	Up to \$167.50	\$0
 	a day	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	 	 	
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0
 		 	
 		 	
 		 	
 		 	
 		 	
 		 	
 		 	

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

PLAN M

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

***Once you have been billed \$183 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 \$183 of Medicare Approved Amounts*	\$0	\$0	\$183
 	 	 	(Part B
 	 	 	Deduc-
 	 	 	tible)
Remainder of Medicare Approved Amounts	Generally	Generally	\$0
 	80%	20%	
Part B Excess Charges (Above Medicare Approved Amounts)	 	 	
	\$0	\$0	All Costs
BLOOD	 	 	
First 3 pints	\$0	All costs	\$0
Next \$183 of Medicare Approved Amounts*	\$0	\$0	\$183

 	 	 	(Part B
 	 	 	Deduc-
 	 	 	tible)
Remainder of Medicare	 	 	
Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY	 	 	
SERVICES—Tests for	 	 	
diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE	 	 	
Medicare Approved	 	 	
Services	 	 	
—Medically necessary	 	 	
skilled care services	 	 	
and medical supplies	100%	\$0	\$0
—Durable medical	 	 	
equipment	 	 	
First \$183 of	 	 	
Medicare Approved	 	 	
Amounts	\$0	\$0	\$183
 	 	 	(Part B
 	 	 	Deduc-
 	 	 	tible)
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	20% and
 	 	lifetime	amounts
 	 	maximum	over the
 	 	benefit of	\$50,000
 	 	\$50,000	lifetime
 	 	 	maximum

PLAN N

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 \$1,340	\$1,340	\$0
 	 	(Part A	
 	 	Deduc-	
 	 	tible)	
61st thru 90th day	All but \$335	\$335	\$0
 	a day	a day	
91st day and after:	 	 	
-While using 60	 	 	
lifetime reserve days	All but \$670	\$670	\$0
 	a day	a day	
-Once lifetime reserve	 	 	
days are used:	 	 	
-Additional 365 days	\$0	100% of	\$0**
 	 	Medicare	
 	 	Eligible	
 	 	Expenses	
-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	\$0	\$0
 	amounts	 	
21st thru 100th day	All but \$167.50	Up to \$167.50	\$0
 	a day	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	 	 	
You must meet Medicare's	All but very	Medicare	\$0

requirements, including	limited	copayment/	
a doctor's certification	copayment/	coinsurance	
of terminal illness	coinsurance	 	
 	for outpatient	 	
 	drugs and	 	
 	inpatient	 	
 	respite care	 	

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

PLAN N

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

*Once you have been billed \$183 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 \$183 of Medicare	 	 	
Approved Amounts*	\$0	\$0	\$183
 	 	 	(Part B
 	 	 	Deduc-
 	 	 	tible)
Remainder of Medicare	 	 	
Approved Amounts	Generally	Balance,	Up to \$20
 	80%	other than	per office
 	 	up to \$20	visit and
 	 	per office	up to \$50
 	 	visit and	per
 	 	up to \$50	emergency
 	 	per	room
 	 	emergency	visit. The
 	 	room visit.	copayment
 	 	The	of up to
 	 	copayment	\$50 is
 	 	of up to	waived if
 	 	\$50 is	the

 	 	waived if	insured is
 	 	the insured	admitted
 	 	is admitted	to any
 	 	to any	hospital
 	 	hospital	and the
 	 	and the	emergency
 	 	emergency	visit is
 	 	visit is	covered as
 	 	covered as	a Medicare
 	 	a Medicare	Part A
 	 	Part A	expense.
 	 	expense.	
Part B Excess Charges	 	 	
(Above Medicare	 	 	
Approved Amounts)	\$0	\$0	All costs
BLOOD	 	 	
First 3 pints	\$0	All Costs	\$0
Next \$183 of Medicare	 	 	
Approved Amounts*	\$0	\$0	\$183
 	 	 	(Part B
 	 	 	Deduc-
 	 	 	tible)
Remainder of Medicare	 	 	
Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY	 	 	
SERVICES-Tests for	 	 	
diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE	 	 	
Medicare Approved	 	 	
Services	 	 	
-Medically necessary	 	 	
skilled care services	 	 	
and medical supplies	100%	\$0	\$0
-Durable medical	 	 	
equipment	 	 	
First \$183 of	 	 	
Medicare Approved	 	 	
Amounts*	\$0	\$0	\$183
 	 	 	(Part B
 	 	 	Deduc-
 	 	 	tible)
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	20% and
 	 	lifetime	amounts
 	 	maximum	over the
 	 	benefit of	\$50,000
 	 	\$50,000	lifetime
 	 	 	maximum

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992 ;-- Am. 2002, Act 304, Imd. Eff. May 10, 2002 ;-- Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006 ;-- Am. 2009, Act 220, Imd. Eff. Jan. 5, 2010 ;-- Am. 2018, Act 429, Eff. Mar. 20, 2019

Compiler's Notes: In Plans K and L, a superscript numeral "1" has been substituted wherever a diamond symbol should occur.

Popular Name: Act 218