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

\*\*\*\*\* 500.3815.amended THIS AMENDED SECTION IS EFFECTIVE MARCH 20, 2019 \*\*\*\*\*

# 500.3815.amended 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:

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BENEFIT CHART OF MEDICARE SUPPLEMENT PLANS SOLD ON OR AFTER JUNE 1, 2010
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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	В	C**	D	F F* **	G/G*
Basic,	Basic,	Basic,	Basic,	Basic,	Basic,
including	including	including	including	including	including
100% Part					
	100% Part				
B coin-	B coinsur-				
surance	ance	ance	ance	ance	ance
		Skilled	Skilled	Skilled	Skilled
		Nursing	Nursing	Nursing	Nursing
		Facility	Facility	Facility	Facility
		Coinsur-	Coinsur-	Coinsur-	Coinsur-

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	ance	ance	ance	ance
	Part A Deductible			Part A Deductible
	Part B Deductible		Part B Deductible	
				Part B Excess (100%)
	Foreign Travel Emergency	Travel	Travel	Foreign Travel Emergency

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

<sup>\*</sup> 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
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 a day	\$670 a day	\$0
<pre>-Once lifetime reserve   days are used:</pre>			
-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 Medicareapproved 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 Medicare's requirements including a doctor's certification of terminal illness	copayment/	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 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.

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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	d 0		۵,0		¢102
Medicare Approved Amounts*	\$0		\$0		\$183 (Part B
Alloures					Deductible)
Remainder of Medicare					Deductible,
Approved Amounts	80%		20%		\$0
Part B Excess Charges					
(Above Medicare					
Approved Amounts)	\$0		\$0		All Costs
BLOOD	·		<u> </u>		
First 3 pints	\$0		All (	Costs	\$0
Next \$183 of	[				ľ
Medicare	\$0		\$0		\$183
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Approved 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
<pre>-Durable medical</pre>			
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	40	1000 5	40+4
	\$0	100% of	\$0**
		Medicare	
		Eligible	
Dorrand the		Expenses	
-Beyond the Additional 365 days	ė n	\$0	All Costs
SKILLED NURSING	30	Ş 0	AII COSCS
FACILITY			
CARE*			
You must meet			
Medicare's			
requirements, including			
requirements, including	I	ı	ı

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		
01	amounts	\$0	\$0
21st thru 100th day	All but	\$0	Up to
	\$167.50 a day	1. 2	\$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 copayment/ coinsurance	Medicare copayment/ coinsurance	\$0
You must meet Medicare's	for outpatient		
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,				
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
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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 -Durable medical equipment First \$183 of Medicare	100%	\$0	\$0
Approved Amounts*  Remainder of Medicare	\$0	\$0	\$183 (Part B Deductible)
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.

	<del> </del>	· · · · · · · · · · · · · · · · · · ·
MEDICARE PAYS	PLAN PAYS	YOU PAY
All but	\$1,340	\$0
\$1,340	(Part A	
	Deductible)	
All but	\$335	\$0
\$335 a day	a day	
_		
All but	\$670	\$0
\$670 a day	a day	
\$0	100% of	\$0**
	Medicare	
	Eligible	
	Expenses	
\$0	\$0	All Costs
	All but \$1,340 All but \$335 a day All but \$670 a day	All but \$1,340 (Part A Deductible) All but \$335 a day  All but \$670 a day  \$0  100% of Medicare Eligible Expenses

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requirements, including having been in a hospital for at least 3 days and entered a Medicareapproved facility within 30 days after leaving the hospital			
First 20 days	All approved		
21 100	amounts	\$0	\$0
21st thru 100th day	All but	Up to	\$0
101 1 1 - 5	\$167.50 a day	\$167.50 a day	7.1.1
101st day and after	\$0	\$0	All costs
BLOOD			1.0
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
	All but very		\$0
		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	D		1 1 1 1 6

\*\*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
	MEDICARE FAIS	FUAN FAIS	100 FAI
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			

Approved Amounts*  Approved Amounts	First 3 pints	\$0	All Costs	\$0
Approved Amounts 80% 20% \$0  CLINICAL LABORATORY SERVICES— Tests for diagnostic services 100% \$0  PARTS A & B  HOME HEALTH CARE Medicare Approved Services	Next \$183 of Medicare Approved Amounts*	\$0	(Part B	\$0
CLINICAL LABORATORY SERVICES— Tests for diagnostic services  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 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 Remainder of charges  \$0 \$0 \$250 80% to a 20% and lifetime maximum benefit \$50,000 of \$50,000 lifetime				
Tests for diagnostic services		80% 	20%	\$0
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   \$0    -Durable medical   equipment   First \$183 of   Medicare Approved   \$0   \$183   \$0    Remainder of Medicare   Approved Amounts   \$0%   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   \$0   \$250   \$0   \$0   \$0   \$0   \$0   \$0   \$0				
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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  OTHER BENEFITS—NOT COVERED BY MEDICARE  FOREIGN TRAVEL— Not covered by Medicare Medically necessary emergency care services beginning during the first \$0 days of each trip outside the USA First \$250 each calendar year Remainder of charges  \$0  80% to a 20% and lifetime maximum over the benefit \$50,000 lifetime		1008	¢ 0	ė n
HOME HEALTH CARE Medicare Approved Services -Medically necessary skilled care services and medical supplies			<u> </u>	الم
Medicare Approved Services  -Medically necessary skilled care services and medical supplies -Durable medical equipment First \$183 of Medicare Approved \$0 \$183 \$0 Amounts*  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 \$0 \$250 Remainder of charges  \$0 \$0 \$0 \$250 80% to a 20% and and and iffetime amounts maximum over the benefit \$50,000 of \$50,000 lifetime	-	TARIS A & B	1	1
Services -Medically necessary skilled care services and medical supplies -Durable medical equipment First \$183 of Medicare Approved \$0 \$183 \$0 Amounts*  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 \$0 \$250 Remainder of charges \$0 \$0 \$0 \$250 Bonefit \$50,000 of \$50,000 lifetime				
-Medically necessary skilled care services and medical supplies				
skilled care services and medical supplies				
and medical supplies -Durable medical equipment First \$183 of Medicare Approved \$0 \$183 \$0 Amounts*  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 \$0 \$250 Remainder of charges \$0 \$0 \$0 \$20% and lifetime amounts maximum over the benefit \$50,000 of \$50,000 lifetime				
-Durable medical equipment First \$183 of Medicare Approved \$0 \$183 \$0 Amounts* 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 \$0 \$250 Remainder of charges \$0 80% to a 20% and lifetime amounts maximum over the benefit \$50,000 lifetime		100%	\$0	\$0
First \$183 of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts  Remainder of Medicare Approved Amounts  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 Remainder of charges  \$0  80% to a 20% and lifetime amounts maximum over the benefit \$50,000 lifetime				
Medicare Approved Amounts*  Remainder of Medicare Approved Amounts 80%  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 \$0 \$250 Remainder of charges \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	equipment			
Amounts*  Remainder of Medicare Approved Amounts  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 Remainder of charges  \$0 \$0 \$250  80% to a 20% and lifetime amounts maximum over the benefit \$50,000 of \$50,000 lifetime	First \$183 of			
Remainder of Medicare Approved Amounts  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 Remainder of charges  \$0  \$0  \$0  \$250  \$250  \$80% to a lifetime amounts maximum over the benefit \$50,000 of \$50,000 lifetime	Medicare Approved	\$0	1	\$0
Remainder of Medicare Approved Amounts  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 Remainder of charges  \$0  \$0  \$0  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$250  \$2	Amounts*		(Part B	
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 \$0 \$250 Remainder of charges \$0 80% to a 20% and lifetime amounts maximum over the benefit \$50,000 of \$50,000 lifetime			Deductible)	
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 Remainder of charges  \$0 \$0 \$250  80% to a 20% and lifetime amounts maximum over the benefit \$50,000 of \$50,000 lifetime				
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 Remainder of charges  \$0 \$0 \$250  80% to a 20% and lifetime amounts maximum over the benefit \$50,000 lifetime		<del></del>	<u> </u>	\$0
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 Remainder of charges  \$0 \$0 \$250  80% to a 20% and lifetime amounts maximum over the benefit \$50,000 of \$50,000 lifetime	OTHER BENEFIT:	S-NOT COVERED BY ME	EDICARE	
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges \$0 \$0 \$0 \$250 80% to a 20% and lifetime amounts maximum over the benefit \$50,000 of \$50,000 lifetime				
emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges  \$0 \$0 \$250 80% to a 20% and lifetime amounts maximum over the benefit \$50,000 of \$50,000 lifetime				
beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges  \$0 \$0 \$250 80% to a 20% and lifetime amounts maximum over the benefit \$50,000 of \$50,000 lifetime				
first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges  \$0 \$0 \$250 80% to a 20% and lifetime amounts maximum over the benefit \$50,000 of \$50,000 lifetime				
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				
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				
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				
Remainder of charges \$0 80% to a 20% and lifetime amounts maximum over the benefit \$50,000 of \$50,000 lifetime		40	¢0	\$250
lifetime amounts maximum over the benefit \$50,000 of \$50,000 lifetime		I.	1'	1'
maximum over the benefit \$50,000 of \$50,000 lifetime	Remainder of charges			
benefit \$50,000 of \$50,000 lifetime			1	
of \$50,000 lifetime				•
maximum			of \$50,000	•
				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	\$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			

lifatima magazza	ı	ı	I
lifetime reserve	All but	\$670	\$0
days	\$670 a day	a day	50
-Once lifetime	15070 a day	a day	
reserve			
days are used:			
-Additional 365 days			
-Additional 303 days	\$0	100% of	\$0**
	30	Medicare	30
		Eligible	
		Expenses	
-Beyond the		EXPENSES	i
Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING	l ·		TITT CODED
FACILITY			
CARE*			i
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 meet	for outpatient		
Medicare's	], ,		
requirements,	drugs and		
including a doctor's	inpatient		
certification of	respite care		
terminal illness		<u> </u>	<u> </u>

\*\*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 D

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.

		J	
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-			
In or out of the hospital			
and outpatient hospital			
treatment, such as			

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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 Deductible)
Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare	80%	20%	\$0
Approved Amounts)	\$0	\$0	All Costs
BLOOD First 3 pints Next \$183 of Medicare	\$0	All Costs	\$0
Approved Amounts*	\$0	\$0	\$183 (Part B Deductible)
Remainder of Medicare	0.0%	0.0%	d O
Approved Amounts CLINICAL LABORATORY SERVICES—	80%	20%	\$0
Tests for diagnostic services	100%	\$0	\$0
diagnostic services	PARTS A & B	Ιν σ	γο
HOME HEALTH CARE Medicare Approved Services -Medically necessary skilled care services and medical supplies -Durable medical equipment First \$183 of Medicare Approved	100%	\$0 \$0	\$0 \$183
Amounts*	ľ	i e	(Part B
			Deductible)
Remainder of Medicare	80%	20%	\$0
Approved Amounts OTHER BENEFITS-	80% -NOT COVERED BY MEI		<b>Ι</b> ν ∪
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 Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
Dandarad Thursday, April 10, 2010	Dogo 11 M	iahigan Campilad Lawa Ca	malete Through DA 2 of 2010

# 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.

emergency deductible.			
SERVICES	MEDICARE	AFTER YOU	IN ADDITION
	PAYS	PAY	TO
		\$2,240	\$2,240
		DEDUCTIBLE * * ,	DEDUCTIBLE**,
		PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and	İ		
board, general nursing			
and miscellaneous			
services and supplies			
First 60 days	All but	\$1,340	\$0
riibe oo dayb	\$1,340	(Part A	
	VI, 340	Deductible)	
61st thru 90th day	All but	\$335	\$0
oist thin Joth day	1	I'	٥
Olat day and often	\$335 a day	a day	
91st day and after			
-While using 60			
lifetime reserve		4600	4.0
days	All but	\$670	\$0
2 1 5 1 1	\$670 a day	a day	
-Once lifetime			
reserve			
days are used:			
-Additional 365	1		
days	\$0	100% of	\$0***
		Medicare	
		Eligible	
		Expenses	
-Beyond the			
Additional 365	1.		
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	ľ
101st day and after	\$0	\$0	All costs
	T'	1'	<u> </u>

BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE			
	limited	Medicare copayment/ coinsurance	\$0
You must	for		
<pre>meet Medicare's requirements,</pre>	outpatient		
including a doctor's	drugs and		
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.

SERVICES	MEDICARE	AFTER YOU	IN ADDITION
	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		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			
<pre>-Medically necessary   skilled care services</pre>			
and medical supplies	100%	\$0	\$0
-Durable medical	1000	۲۰	70
equipment			
First \$183 of			
Medicare Approved	\$0	\$183	\$0
Amounts*		(Part B	<u> </u>
		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 \$50,0	•
			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	IN ADDITION
		PAY	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

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	\$1,340	(Part A	İ
	717310	Deductible)	
61st thru 90th day	All but	\$335	\$0
91st day and after -While using 60	\$335 a day	a day	
lifetime reserve			
days	All but	\$670	\$0
-Once lifetime	\$670 a day	a day	
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	40	40
21st thru 100th day	amounts	\$0 Up to	\$0 \$0
zise ema rocen aa,	\$167.50 a day	\$167.50 a day	
_ 101st day and after	_	\$0	All costs
BLOOD			
First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE	100%	Ş U	50
HODITCE CARE	All but very		\$0
	limited	Medicare	
	copayment/	copayment/	
Von much most	coinsurance	coinsurance	
You must meet Medicare's	for outpatient		
requirements,	drugs and		
including a doctor's	inpatient		
certification of	respite care		
terminal illness	C. II D A. 1	C	

\*\*\*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.

deductible.	LMEDICARE	D 3 3 4 C	7 BEE 17011	The ADDITION
SERVICES	MEDICARE	PAYS	AFTER YOU	IN ADDITION
			PAY	TO
			\$2,240	\$2,240
			DEDUCTIBLE**,	DEDUCTIBLE**,
			PLAN PAYS	YOU PAY
MEDICAL EXPENSES-				
In or out of the				İ
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*	ľ		·	(Unless
				Part B
				Deductible
				has been
				met)
Remainder of				
Medicare				
Approved Amounts	80%		20%	\$0
	00%		20%	٦٥
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
	00.0		200	Y ~
CLINICAL LABORATORY				
SERVICES—				
Tests for	I			I

diagnostic services  10	00%	<b> </b> \$0	<b> </b> \$0	
	PARTS	5 A & B	-	
HOME HEALTH CARE				
Medicare Approved				
Services				
-Medically necessary				
skilled care service	-			
and medical supplies	100%		\$0	\$0
—Durable medical				
equipment				
First \$183 of	4.0		* 0	4100
Medicare Approved	\$0		\$0	\$183
Amounts*				(Part B
Remainder of Medicar				Deductible)
Approved Amounts	e    80%		20%	\$0
				<del>3</del> 0
FOREIGN TRAVEL—	115-1101	CAEKED BI MED	TCARE	T
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
	ĺ		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 in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

## PLAN K MEDICARE (PART A)-HOSPITAL SERVICES-PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1,340	\$670 (50% of Part A	\$670 (50% of Part A
61st thru 90th day	All but \$335 a day	Deducti- ble) \$335 a day	Deductible) 1 \$0
91st day and after: -While using 60			
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	l ·	\$0
	2	
	100% of Medicare Eligible Expenses	\$0***
0	40	All Costs
0	\$ U	All Costs
11		
	¢۸	\$0
		Up to
		\$83.75
	l '	a day 1
	\$0	All costs
-	50%	50% 1
.00%	\$0	\$0
	50% of copayment/ coinsur- ance	50% of Medicare copayment/ coinsurance 1
· · J ·		
npatient		
	0 0 0 11 approved mounts 11 but 167.50 a ay 0	11 approved mounts 11 but 167.50 a ay 0 0 50% 00% 00% 11 but very imited opayment/ oinsurance for utpatient 100% of Medicare Eligible Expenses 0 \$0 50% 50 50% 50% 50% 50% 50% 50% 50% 50%

\*\*\*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.

noted with an asterisk), your fart b beddetible will have been met for the calcular 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,		l	l		

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<pre>inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,   First \$183 of    Medicare Approved    Amounts****</pre>	\$0	\$0	\$183 (Part B Deductible) **** 1
Preventive Benefits for Medicare covered services  Remainder of Medicare	Generally 75% or more of Medicare ap- proved amounts Generally 80%	of Medi- care approved amounts	All costs above Medi- care approved amounts Generally
Approved Amounts	Generally 80%	10%	10% 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 \$5,240)*
BLOOD First 3 pints	\$0	50%	50% 1
Next \$183 of Medicare Approved Amounts****	\$0	\$0	\$183 (Part B Deductible) **** 1
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 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<sup>1</sup> 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.

you have been out of the hospital and	•	<del>,                                      </del>	
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION**			
Semiprivate room and			
board, general nursing			
and miscellaneous			
services and supplies	İ		
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
orbe ellia your day	\$335 a day	a day	
91st day and after:	l day	a day	
-While using 60			
lifetime reserve days	All but	\$670	\$0
liletime reserve days		I.	P 0
-Once lifetime reserve	\$670 a day	a day	
days are used:	\$0	1000 - 5	\$0***
-Additional 365 days	\$ U	100% of	\$U^^^
		Medicare	
		Eligible	
		Expenses	
-Beyond the	1.0		
Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's	İ		
requirements, including	İ		
having been in a hospital	İ		
for at least 3 days and	İ		
entered a Medicare-			
approved facility within			
30 days after leaving the			
hospital			
First 20 days	All approved		
TITUC 20 days	amounts	\$0	\$0
21st thru 100th day	All but	Up to	Up to
ZIBC CIII U TUUCII Uay	\$167.50 a	\$125.63	\$41.88
	1'		
101 4	day	a day	a day 1
101st day and after	\$0	\$0	All costs
BLOOD	40		050 1
First 3 pints	\$0	75%	25% 1
Additional amounts	100%	\$0	\$0
HOSPICE CARE	1		
	I	75% of	25% of

		copayment/ coinsur- ance	copayment/ coinsurance 1
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.

noted with an asterisk), your rare b L		1	
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	1.0		4100
Medicare Approved	\$0	\$0	\$183
Amounts***			(Part B Deducti-
			ble)**** 1
Preventive Benefits for	Generally 75%	    Remainder	All costs
Medicare covered	or more of	of Medi-	above Medi-
services	Medicare	care	care
BCI VICCB	approved	approved	approved
	amounts	amounts	amounts
Remainder of Medicare	Generally	Generally	Generally
Approved Amounts	80%	15%	5% 1
Part B Excess Charges	\$0	\$0	All costs
(Above Medicare		1	(and they do
Approved Amounts)			not count
			toward
			annual out-
			of-pocket
			limit of
			\$2,620)*
BLOOD			
First 3 pints	\$0	75%	25% 1
Next \$183 of			

Medicare Approved	\$0	\$0	\$183
Amounts****			(Part B
			Deductible) 1
Remainder of Medicare	Generally	Generally	Generally
Approved Amounts	80%	15%	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	100%	\$0	\$0
-Durable medical			
equipment			
First \$183 of			
Medicare Approved	\$0	\$0	\$183
Amounts****			(Part
			B Deducti-
			ble) 1
Remainder of Medicare			
Approved Amounts	80%	15%	5% 1

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

\*\*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	MEDICANE PAIS	FIAN FAIS	100 PA1
First \$183 of Medicare Approved Amounts*  Remainder of Medicare	\$0	\$0	\$183 (Part B Deduc- tible)

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Approved Amounts	Generally 80%	Generally 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
			Deduc- tible)
Remainder of Medicare			CIDIE)
Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY	1	20%	γ o
SERVICES—Tests for			
diagnostic services	100%	\$0	\$0
	PARTS A & B	<u>                                     </u>	<u>  +                                   </u>
HOME HEALTH CARE	I	1	1
Medicare Approved			
Services			
-Medically necessary			
skilled care services			
and medical supplies	100%	\$0	\$0
<pre>-Durable medical</pre>			
equipment			
First \$183 of			
Medicare Approved			+100
Amounts	\$0	\$0	\$183
			(Part B
			Deduc- tible)
Remainder of Medicare			(CIDIE)
Approved Amounts	80%	20%	\$0
	NOT COVERED BY ME		14.0
FOREIGN TRAVEL—Not		1	
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 benefit of	over the \$50,000
		\$50,000	lifetime
		750,000	maximum
	DIAN N	J	mazzimam

### 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.

		<del></del>	<del></del>
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION* Semiprivate room and board, general nursin and miscellaneous services and supplies			

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First 60 days	All but \$1,340	\$1,340 (Part A Deduc- tible)	\$0
61st thru 90th day	All but \$335	\$335	\$0
91st day and after: -While using 60 lifetime reserve	a day	a day	
days	All but \$670 a day	\$670 a day	\$0
<pre>-Once lifetime reserve   days are used:</pre>			
-Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
-Beyond the Additional 365 days	l¢n	<b> </b>  \$0	All Costs
SKILLED NURSING		ļ ,	AII COSCS
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		1
21st thru 100th day	All but \$167.50 a day	Up to \$167.50 a day	\$0
	\$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
· ,	limited	copayment/	
a doctor's		l .	
certification	copayment/	coinsurance	
of terminal illness	coinsurance		
	for outpatient		
	drugs and inpatient		
	respite care		
	L CDPICC Care	<u> </u>	<u> </u>

<sup>\*\*</sup>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.

with an asterisk), your Part B deductible		<del>1                                    </del>	
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-			
IN OR OUT OF THE			
HOSPITAL AND OUTPATIENT			
HOSPITAL TREATMENT, such		İ	
as Physician's services,		İ	
inpatient and outpatient		İ	
medical and surgical			
services and supplies,			
physical and speech			
therapy, diagnostic			
tests, durable medical			
equipment			
First \$183 of Medicare	i		
Approved Amounts*	\$0	\$0	\$183
Approved Amounts	30	70	(Part B
			Deduc-
			1
Domainday of Madigaya			tible)
Remainder of Medicare	Conorally	Palanca	TID +0 000
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.	Chpenbe.
Part B Excess Charges			
(Above Medicare	i		
Approved Amounts)	\$0	\$0	All costs
BLOOD	1	70	AII COSCS
First 3 pints	\$0	All Costs	\$0
Next \$183 of Medicare	30	AII COSES	٥٩٥
Approved Amounts*	\$0	30	\$183
Approved Amounts"	٦٠	\$0	I'
			(Part B
			Deduc-
Domaindon of Madiana			tible)
Remainder of Medicare	0.0%		d O
Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES—Tests for	l	I	I

diagnostic services	100%	\$0	\$0
I	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	100%	\$0	\$0
Amounts*	\$0	\$0	\$183 (Part B Deduc- tible)
Remainder of Medicare			
Approved Amounts	80%	20%	\$0
OTHER BENEFITS	-NOT COVERED BY ME	DICARE	
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 Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$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 note: In Plans K and L, a superscript numeral "1" has been substituted wherever a diamond symbol should occur.

Popular name: Act 218