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 100% Part	Basic, including 100% Part	Basic, including 100% Part	Basic, including 100% Part	Basic, including 100% Part	Basic, including 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

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

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	$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,			
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
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			

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 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			
lifetime reserve days	All but $670 a day	$670 a day	$0

—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 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 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.

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			
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

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	AFTER YOU	IN ADDITION
	PAYS	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
	$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.

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			
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	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
	$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 $2,240 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO $2,240 DEDUCTIBLE**, 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	$163 (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 Amounts*	$0	$0	$183 (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

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*

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% 80%	$0 $0 15%	$0 $183 (Part B Deducti- ble) 1 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%	$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	All but very	Medicare	$0
requirements, including	limited	copayment/	
a doctor's	copayment/	coinsurance	
certification of	coinsurance		
terminal 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 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