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:

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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-
		ance	ance	ance	ance
	Part A				

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Deductible	Deductible	Deductible	Deductible	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 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 Rendered Monday, July 7, 2025 Page 2 Michigan Compiled Laws Complete Through PA 5 of 2025

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
61st thru 90th day	All but	\$335	Deductible) \$0
orst thru yoth day	\$335 a day	a day	β U
91st day and after:	l a day	a day	
-While using 60			
	All but	\$670	\$0
-	\$670 a day	a day	i'
-Once lifetime reserve	<u> </u>	_	
days are used:			
-Additional 365 days	\$0	100% of	\$0**
		Medicare	
		Eligible	
D 1 11		Expenses	
-Beyond the	Ġ O	d 0	711 0000
	\$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 21st thru 100th day	All approved amounts All but \$167.50 a day	\$0 \$0	\$0 Up to \$167.50 a day
101st day and after	1 .	\$0	All costs
BLOOD First 3 pints Additional amounts HOSPICE CARE You must meet Medicare's requirements including a doctor's certification of terminal	copayment/	3 pints \$0 Medicare copayment/ coinsurance	\$0 \$0 \$0
illness	for outpatient drugs and inpatient respite care	coinsurance	

**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.

	T		
SERVICES	MEDICARE PAYS	B 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		.	<u> </u>
Medicare .	\$0	\$0	\$183
Approved Amounts*			(Part B
			Deductible)
Remainder of Medicare	l	1	l

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.

have been out of the hospital and ha	ave not received skilled care	in any other facility it	or oo 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	ŞU	\$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-			
circula a ricalcale	ı	I	ı

approved facility within 30 days after leaving the hospital First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$167.50 a day	\$0	Up to \$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 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 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.

with all asterisk), your Part B Deductible will have been fliet for the calendar year.				
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY	
MEDICAL EXPENSES-				
In or out of the hospital			1	
and outpatient hospital				
treatment, such as			1	
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	
D ' 1 C M 1'			Deductible)	
Remainder of Medicare	0.00		40	
Approved Amounts	80%	20%	\$0	
Part B Excess Charges				
(Above Medicare	d 0	d 0	All Costs	
Approved Amounts)	\$0	\$0	All Costs	
BLOOD	40	711 0000	C O	
First 3 pints	\$0	All Costs	\$0	
Next \$183 of Medicare	ė n	\$0	\$183	
Approved Amounts*	\$0	٦٠	(Part B	
Remainder of Medicare			1 '	
remainder of Medicare	I	I	Deductible)	

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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	ľ
91st day and after			
-While using 60			
lifetime reserve days	All but	\$670	\$0
days	\$670 a day	a day	ρ U
-Once lifetime	1,40.00 11.11.11		
reserve			
days are used:			
-Additional 365 days	\$0	100% of	\$0**
	Ş	Medicare	Ş
		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 \$167.50 a day	Up to \$167.50 a day	\$0
	\$0		All costs
BLOOD			
First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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

PLAN 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*	30	(Part B	\$ U
Amounts		Deductible)	
Remainder of Medicare		Deducerbie,	
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	

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		Deductible)	
Remainder of Medicare	0.00		40
	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES—			
Tests for	1000		
	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 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	\$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 (Part A Deductible) 61st thru 90th day All but \$335 a day 91st day and after -While using 60 lifetime reserve days -Once lifetime reserve MEDICARE PAYS PLAN PAYS YOU PAY All but \$1,340 \$0 (Part A Deductible) \$335 a day \$335 a day \$41 but \$670 a day -Once lifetime reserve	have been out of the hospital and have not received skilled care in any other facility for ob days in a row.			
Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days All but \$1,340 (Part A Deductible) 61st thru 90th day All but \$335 a day 91st day and after -While using 60 lifetime reserve days -Once lifetime	SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
board, general nursing and miscellaneous services and supplies First 60 days All but \$1,340 (Part A Deductible) 61st thru 90th day All but \$335 \$0 91st day and after -While using 60 lifetime reserve days All but \$670 a day -Once lifetime	HOSPITALIZATION*			
and miscellaneous services and supplies First 60 days All but \$1,340 (Part A Deductible) 61st thru 90th day All but \$335 91st day and after -While using 60 lifetime reserve days All but \$670 \$670 a day Once lifetime	Semiprivate room and			
services and supplies First 60 days All but \$1,340 (Part A Deductible) 61st thru 90th day All but \$335 a day 91st day and after -While using 60 lifetime reserve days All but \$670 a day -Once lifetime	board, general nursing			
First 60 days All but \$1,340 (Part A Deductible) 61st thru 90th day All but \$335 \$0 91st day and after -While using 60 lifetime reserve days All but \$670 a day -Once lifetime				
\$1,340 (Part A Deductible) 61st thru 90th day All but \$335 91st day and after -While using 60 lifetime reserve days All but \$670	- -			
Deductible) 61st thru 90th day All but \$335 91st day and after -While using 60 lifetime reserve days All but \$670 \$670 a day -Once lifetime	First 60 days		\$1,340	\$0
61st thru 90th day All but \$335 91st day and after -While using 60 lifetime reserve days All but \$670 -Once lifetime \$670 a day a day		' '	,	
91st day and after —While using 60 lifetime reserve days —Once lifetime \$335 a day a day \$670 \$670 \$670 \$0 \$411 but \$670 \$670 \$0 \$0				
91st day and after -While using 60 lifetime reserve days All but \$670 \$0 a day -Once lifetime	2	!	! '	\$0
-While using 60 lifetime reserve days All but \$670 \$0 -Once lifetime \$670 a day a day		\$335 a day	a day	
lifetime reserve days All but \$670 \$0 -Once lifetime \$670 a day a day	-			
days All but \$670 \$0 -Once lifetime \$670 a day \$0	5			
-Once lifetime \$670 a day a day	lifetime reserve			
-Once lifetime	days		I.	\$0
		\$670 a day	a day	
reserve	-Once lifetime			
	reserve	l		

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days are used: -Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
-Beyond the			
Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital			
First 20 days	All approved		
21st thru 100th day	amounts All but \$167.50 a day	\$0 Up to \$167.50 a day	\$0 \$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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

PLAN 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.

with all asterisk), your fart B Deductione will have been flict for the calcillat 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				

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therapy, diagnostic tests, durable medical equipment,			
First \$183 of Medicare Approved	\$0	\$0	\$183
Amounts*	Ç	٥	(Part B Deductible)
Remainder of Medicare			
Approved Amounts Part B Excess Charges	80%	20%	\$0
(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
ripploved impaired		,	(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			
	100%	\$0	\$0
-Durable medical	1000		
equipment			
First \$183 of			
Medicare Approved	\$0	\$0	\$183
Amounts*			(Part B
Remainder of Medicare			Deductible)
Approved Amounts	80%	20%	\$0
	-NOT COVERED BY MED		<u> </u> + •
FOREIGN TRAVEL—	1	<u> </u>	
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 benefit	over the
		of \$50,000	\$50,000 lifetime
		750,000	maximum
DIAN E OD III			

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
	\$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			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	All approved		
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but	Up to	\$0
Zisc ciiru 100cii udy	\$167.50 a day	\$167.50 a day	Y O
	\$0 a day	\$0 a day	All costs
BLOOD	γ ·		MII COBCB
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE		T ~	T - T
	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,	İ	İ	
First \$183 of			
	\$0	\$183	\$0
Amounts*	ľ	(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	% PARTS A & B	\$0 \$	0
HOME HEALTH CARE Medicare Approved Services -Medically necessary skilled care services and medical supplies -Durable medical equipment First \$183 of Medicare Approved Amounts*	100%	\$0 \$183 (Part B Deductible)	\$0 \$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
	S-NOT COVERED I	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 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$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.

	i	1	1
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
1	\$335 a day	a day	ľ
91st day and after	, , , , , , , , , , , , , , , , , , , ,	1	

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-While using 60	İ	İ	İ
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	
Darrand the		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	All approved		
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day		Up to	\$0
-	\$167.50 a day	\$167.50 a day	
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE	100%	ļ	
11021 101 01111	All but very		\$0
	limited	Medicare	
	copayment/	copayment/	
W	coinsurance	coinsurance	
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 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.		-	
SERVICES	MEDICARE PAYS	AFTER YOU	IN ADDITION
		PAY	TO
		\$2,240	\$2,240
		DEDUCTIBLE**,	DEDUCTIBLE**,
		PLAN PAYS	YOU PAY
MEDICAL EXPENSES—		1	
In or out of the			
hospital			
and outpatient			
hospital			
treatment, such as			
Physician's services,			
inpatient and			
outpatient			
medical and surgical			
services and			
supplies,			
physical and speech			
therapy, diagnostic			
tests, durable			
medical			
equipment,			
First \$183 of			
Medicare Approved			
	\$0	\$0	\$163
Amounts*			(Unless
			Part B
			Deductible
			has been
			met)
Remainder of			
Medicare			
Approved Amounts	80%	20%	\$0
Part B Excess			
Charges			
(Above Medicare			
Approved Amounts)	\$0	100%	0%
BLOOD	T -		
First 3 pints	\$0	All Costs	\$0
Next \$183 of	 	WII CORCR	
Medicare Approved	\$0	\$0	\$183
Amounts*	50	٦٥	I'
Alliourics			(Unless Part B
			Deductible
			!
			has been
Domaindon of Madiana			met)
Remainder of Medicare	000	200	¢0
Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES—			
Tests for			1,0
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 Approved Amounts*	100% \$0	\$0 \$0	\$0 \$183 (Part B Deductible)
Remainder of Medicare			
Approved Amounts	80%	20%	\$0
OTHER BENEFITS-	NOT COVERED BY MEI	ICARE	
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

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 diamonds¹ 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.

you have been out of the hospital and	mave not received skined ca	ite ili aliy otilel tacil	ity for oo days in a fow.
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 Deducti- ble)	\$670 (50% of Part A Deductible) 1
61st thru 90th day 91st day and after:	All but \$335 a day	\$335 a day	\$0
-While using 60	All but \$670 a day	\$670 a day	\$0
<pre>-Once lifetime reserve days are used: -Additional 365 days</pre>	\$0	100% of	\$0***

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\$50,000

lifetime maximum

benefit of \$50,000

		_	
		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		i i	
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				

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tests, durable medical equipment, First \$183 of Medicare Approved Amounts****	\$0	\$0	\$183 (Part B Deductible) **** 1
Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	Generally 75% or more of Medicare ap- proved amounts Generally 80%	Remainder of Medi- care approved amounts Generally 10%	All costs above Medi- care approved amounts Generally 10% 1
Part B Excess Charges (Above Medicare Approved Amounts)	\$0		All costs (and they do not count toward annual out- of-pocket limit of \$5,240)*
BLOOD First 3 pints Next \$183 of	\$0	50%	50% 1
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 Rendered Monday, July 7, 2025

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with diamonds¹ 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			
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)	<u> </u>
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	
D 1.12		Expenses	
-Beyond the	d 0	40	711 0
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		
FIISC 20 days	amounts	\$0	\$0
21st thru 100th day	All but	Up to	Up to
zisc ciii a 100cii day	\$167.50 a	\$125.63	\$41.88
	day	a day	a day 1
101st day and after	\$0	\$0	All costs
BLOOD	1	7 0	1 33232
First 3 pints	\$0	75%	25% 1
Additional amounts	100%	\$0	\$0
HOSPICE CARE		7 -	
		75% of	25% of
		copayment/	copayment/
		coinsur-	coinsurance 1
		ance	
You must meet			
Medicare's requirements,			
<u>-</u> ,	•	•	•

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	Generally 75%	Remainder	All costs
Medicare covered	or more of	of Medi-	above Medi-
services	Medicare	care	care
	approved	approved	approved
Danish dan af Madinana	amounts	amounts	amounts
Remainder of Medicare	Generally 80%	Generally 15%	Generally
Approved Amounts	80%	124	5% 1
Part B Excess Charges	\$0	\$0	All costs
(Above Medicare			(and they do
Approved Amounts)			not count
TIPPECTON TIMONIES,			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
Dandand Manday, July 7, 2005	D 04	M: 1: 0 :: 11	O

CLINICAL LABORATORY	1		
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%	\$670 (50%
		of Part A	of Part A
		Deduc-	Deduc-
61	-11 1	tible)	tible)
61st thru 90th day	All but \$335	\$335	\$0
01	a day	a day	
91st day and after: -While using 60			
lifetime reserve			
days	All but \$670	\$670	\$0
uays	a day	a day	
-Once lifetime		a day	
reserve			
days are used:			İ
-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	I	l	I

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	\$0	\$0
Filst 20 days	amounts	 	
21st thru 100th day		Up to \$167.50	\$0
zisc ciii a ioocii day	a day	a day	
101st day and after	\$0	\$0	All costs
BLOOD	l l	70	AII COSCS
	Ġ O	2	d 0
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet			
	F 2	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* Remainder of Medicare	\$0	\$0	\$183 (Part B Deduc- tible)
Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges			
(Above Medicare			
Approved Amounts)	\$0	\$0	All Costs

BLOOD	I	I	I
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
	ARTS 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-
Remainder of Medicare			tible)
Approved Amounts	80%	20%	\$0
	S-NOT COVERED BY ME	<u> </u>	
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 maximum	amounts 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

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91st day and after: -While using 60	a day	a day	
lifetime reserve days	All but \$670 a day	\$670 a day	\$0
-Once lifetime reserve			
days are used: -Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
-Beyond the			
Additional 365 days	\$0	\$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet			
Medicare's			
requirements, including having been in a			
hospital			
for at least 3 days and			
entered a Medicare-			
approved facility			
within			
30 days after leaving			
the			
hospital	777	40	40
First 20 days	All approved	\$0	\$0
21st thru 100th day	amounts All but \$167.50	Up to \$167.50	\$0
Zibe ema 100en aay	a day	a day	
101st day and after	\$0	\$0	All costs
BLOOD	1		
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	copayment/ coinsurance	COTHERTALICE	
OT CCTUITHAT TITHEBB	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.

with all algebrash, four fair B deduction will have been first for the carefular fear.				
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY	
MEDICAL EXPENSES-				
IN OR OUT OF THE				

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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 80%	Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare			
Approved Amounts) BLOOD	\$0	\$0	All costs
First 3 pints Next \$183 of Medicare	\$0	All Costs	\$0
Approved Amounts*	\$0	\$0	\$183 (Part B Deduc- tible)
Remainder of Medicare Approved Amounts	 80%	20%	\$0
CLINICAL LABORATORY		200	7 0
SERVICES—Tests for			
diagnostic services	100%	\$0	\$0
HOME HEALTH CARE	PARTS A & B	1	
Medicare Approved Services			

-Medically necessary skilled care services and medical supplies -Durable medical equipment First \$183 of Medicare Approved Amounts*	100%	\$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.

 $\textbf{Compiler's note:} \ In \ Plans \ K \ and \ L, a \ superscript \ numeral \ "1" \ has been \ substituted \ wherever \ a \ diamond \ symbol \ should \ occur.$

Popular name: Act 218