THE MANHATTAN LIFE INSURANCE COMPANY
Outline of Medicare Supplement Coverage-Cover Page
Benefit Plans A, C, F, G, AND N

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020.

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A." Some plans may not be available in your state. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F. The Manhattan Life Insurance Company offers five of the twelve plans available.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants									Medicare first eligible before 2020 only		
	A	B	D	G	G[1]	K	L	M	N	C	F	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Medicare Part B coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓ Copays apply[3]	✓	✓	
Blood (first three pints)	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Part A hospice care coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Skilled nursing facility coinsurance			✓	✓		50%	75%	✓	✓	✓	✓	
Medicare Part A deductible		✓	✓	✓		50%	75%	50%	✓	✓	✓	
Medicare Part B deductible										✓	✓	
Medicare Part B excess charges				✓							✓	
Foreign travel emergency (up to plan limits)			✓	✓				✓	✓	✓	✓	
Out-of-pocket limit in 2020[2]						$5,560[2]	$2,780[2]					

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,340 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN OREGON ZIP CODES
970-972

Attained Age	Female					Male				
	Plan A	Plan C	Plan F	Plan G	Plan N	Plan A	Plan C	Plan F	Plan G	Plan N
0-64	2,063	2,734	2,764	2,031	1,647	2,374	3,143	3,175	2,334	1,891
65	2,063	2,734	2,764	2,031	1,647	2,374	3,143	3,175	2,334	1,891
66	2,063	2,734	2,764	2,031	1,647	2,374	3,143	3,175	2,334	1,891
67	2,063	2,734	2,764	2,031	1,647	2,374	3,143	3,175	2,334	1,891
68	2,154	2,842	2,873	2,120	1,719	2,475	3,268	3,303	2,438	1,974
69	2,238	2,953	2,985	2,214	1,790	2,574	3,394	3,432	2,543	2,056
70	2,323	3,058	3,089	2,298	1,858	2,670	3,514	3,551	2,642	2,136
71	2,392	3,157	3,190	2,382	1,926	2,750	3,630	3,668	2,738	2,212
72	2,461	3,257	3,293	2,465	1,994	2,828	3,745	3,785	2,834	2,290
73	2,533	3,356	3,393	2,548	2,061	2,909	3,860	3,901	2,927	2,369
74	2,602	3,457	3,494	2,631	2,128	2,990	3,974	4,018	3,024	2,448
75	2,672	3,561	3,599	2,716	2,198	3,072	4,093	4,136	3,122	2,527
76	2,738	3,669	3,707	2,803	2,273	3,144	4,217	4,262	3,221	2,613
77	2,798	3,778	3,818	2,891	2,348	3,219	4,342	4,391	3,323	2,699
78	2,866	3,893	3,935	2,982	2,428	3,294	4,475	4,523	3,430	2,790
79	2,933	4,009	4,053	3,078	2,508	3,372	4,609	4,659	3,537	2,882
80	3,002	4,129	4,173	3,173	2,590	3,452	4,746	4,796	3,647	2,977
81	3,066	4,254	4,299	3,274	2,679	3,525	4,889	4,941	3,762	3,078
82	3,128	4,380	4,427	3,376	2,768	3,596	5,036	5,088	3,881	3,183
83	3,197	4,513	4,561	3,483	2,864	3,675	5,189	5,243	4,002	3,291
84	3,265	4,650	4,700	3,594	2,961	3,752	5,346	5,401	4,130	3,404
85	3,336	4,790	4,838	3,705	3,060	3,832	5,505	5,563	4,259	3,517
86	3,409	4,934	4,984	3,819	3,162	3,917	5,672	5,729	4,390	3,633
87	3,484	5,083	5,136	3,936	3,264	4,005	5,841	5,902	4,524	3,753
88	3,562	5,234	5,286	4,056	3,370	4,093	6,015	6,078	4,664	3,875
89	3,633	5,379	5,433	4,173	3,473	4,176	6,184	6,245	4,796	3,991
90	3,703	5,521	5,576	4,286	3,573	4,256	6,348	6,410	4,927	4,108
91	3,763	5,654	5,710	4,391	3,670	4,324	6,500	6,563	5,046	4,217
92	3,816	5,778	5,836	4,489	3,758	4,384	6,642	6,707	5,160	4,320
93	3,862	5,893	5,952	4,582	3,841	4,439	6,774	6,842	5,267	4,415
94	3,905	6,010	6,068	4,674	3,926	4,491	6,908	6,976	5,372	4,513
95	3,954	6,128	6,186	4,768	4,014	4,545	7,044	7,113	5,482	4,613
96	4,032	6,250	6,313	4,865	4,093	4,636	7,186	7,254	5,590	4,704
97	4,114	6,375	6,437	4,960	4,175	4,729	7,326	7,398	5,702	4,798
98	4,196	6,504	6,566	5,061	4,259	4,824	7,475	7,547	5,816	4,894
99	4,280	6,634	6,698	5,161	4,343	4,920	7,625	7,699	5,933	4,992

Premium payable other than annual will be determined according to the following factors:

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

There is a one-time $25.00 policy fee.
A discount factor of .88 is applied for household discount applicants

THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN OREGON ZIP CODES
970-972

Attained Age	Female					Male				
	Plan A	Plan C	Plan F	Plan G	Plan N	Plan A	Plan C	Plan F	Plan G	Plan N
0-64	2,374	3,143	3,175	2,334	1,891	2,728	3,612	3,651	2,684	2,175
65	2,374	3,143	3,175	2,334	1,891	2,728	3,612	3,651	2,684	2,175
66	2,374	3,143	3,175	2,334	1,891	2,728	3,612	3,651	2,684	2,175
67	2,374	3,143	3,175	2,334	1,891	2,728	3,612	3,651	2,684	2,175
68	2,475	3,268	3,303	2,438	1,974	2,845	3,756	3,795	2,802	2,270
69	2,574	3,394	3,432	2,543	2,056	2,958	3,903	3,944	2,924	2,364
70	2,670	3,514	3,551	2,642	2,136	3,069	4,039	4,083	3,038	2,454
71	2,750	3,630	3,668	2,738	2,212	3,162	4,171	4,217	3,146	2,542
72	2,828	3,745	3,785	2,834	2,290	3,253	4,304	4,349	3,256	2,632
73	2,909	3,860	3,901	2,927	2,369	3,344	4,435	4,484	3,366	2,725
74	2,990	3,974	4,018	3,024	2,448	3,436	4,569	4,616	3,476	2,813
75	3,072	4,093	4,136	3,122	2,527	3,530	4,706	4,757	3,589	2,906
76	3,144	4,217	4,262	3,221	2,613	3,613	4,847	4,899	3,704	3,005
77	3,219	4,342	4,391	3,323	2,699	3,696	4,990	5,044	3,821	3,103
78	3,294	4,475	4,523	3,430	2,790	3,786	5,144	5,198	3,943	3,206
79	3,372	4,609	4,659	3,537	2,882	3,878	5,297	5,354	4,067	3,314
80	3,452	4,746	4,796	3,647	2,977	3,968	5,454	5,514	4,193	3,422
81	3,525	4,889	4,941	3,762	3,078	4,050	5,619	5,679	4,325	3,539
82	3,596	5,036	5,088	3,881	3,183	4,134	5,787	5,848	4,459	3,658
83	3,675	5,189	5,243	4,002	3,291	4,223	5,964	6,027	4,601	3,785
84	3,752	5,346	5,401	4,130	3,404	4,312	6,145	6,208	4,746	3,912
85	3,832	5,505	5,563	4,259	3,517	4,405	6,329	6,394	4,894	4,043
86	3,917	5,672	5,729	4,390	3,633	4,502	6,519	6,587	5,045	4,176
87	4,005	5,841	5,902	4,524	3,753	4,604	6,715	6,782	5,199	4,312
88	4,093	6,015	6,078	4,664	3,875	4,706	6,914	6,985	5,358	4,454
89	4,176	6,184	6,245	4,796	3,991	4,801	7,105	7,176	5,513	4,588
90	4,256	6,348	6,410	4,927	4,108	4,893	7,293	7,368	5,662	4,721
91	4,324	6,500	6,563	5,046	4,217	4,970	7,472	7,544	5,801	4,848
92	4,384	6,642	6,707	5,160	4,320	5,041	7,634	7,710	5,932	4,965
93	4,439	6,774	6,842	5,267	4,415	5,102	7,785	7,864	6,052	5,075
94	4,491	6,908	6,976	5,372	4,513	5,162	7,940	8,017	6,175	5,188
95	4,545	7,044	7,113	5,482	4,613	5,224	8,096	8,175	6,299	5,302
96	4,636	7,186	7,254	5,590	4,704	5,330	8,258	8,339	6,426	5,406
97	4,729	7,326	7,398	5,702	4,798	5,435	8,425	8,505	6,554	5,516
98	4,824	7,475	7,547	5,816	4,894	5,544	8,593	8,674	6,685	5,625
99	4,920	7,625	7,699	5,933	4,992	5,654	8,765	8,849	6,818	5,739

Premium payable other than annual will be determined according to the following factors:

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

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THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN OREGON ZIP CODES ALL EXCEPT
970-972

Attained Age	Female					Male				
	Plan A	Plan C	Plan F	Plan G	Plan N	Plan A	Plan C	Plan F	Plan G	Plan N
0-64	1,933	2,561	2,589	1,903	1,543	2,224	2,944	2,974	2,187	1,772
65	1,933	2,561	2,589	1,903	1,543	2,224	2,944	2,974	2,187	1,772
66	1,933	2,561	2,589	1,903	1,543	2,224	2,944	2,974	2,187	1,772
67	1,933	2,561	2,589	1,903	1,543	2,224	2,944	2,974	2,187	1,772
68	2,018	2,663	2,691	1,986	1,610	2,318	3,062	3,095	2,284	1,849
69	2,097	2,766	2,796	2,074	1,677	2,411	3,180	3,216	2,383	1,926
70	2,176	2,865	2,894	2,153	1,741	2,502	3,292	3,327	2,475	2,001
71	2,241	2,957	2,989	2,231	1,804	2,577	3,401	3,436	2,565	2,072
72	2,306	3,051	3,085	2,310	1,868	2,650	3,508	3,546	2,655	2,146
73	2,373	3,144	3,179	2,387	1,930	2,725	3,616	3,654	2,742	2,220
74	2,438	3,239	3,273	2,464	1,994	2,801	3,723	3,764	2,833	2,294
75	2,504	3,336	3,371	2,545	2,059	2,878	3,834	3,875	2,925	2,367
76	2,565	3,437	3,473	2,626	2,130	2,945	3,951	3,993	3,017	2,448
77	2,621	3,540	3,577	2,708	2,200	3,015	4,068	4,114	3,113	2,528
78	2,685	3,647	3,686	2,794	2,275	3,086	4,193	4,237	3,213	2,614
79	2,747	3,756	3,797	2,884	2,350	3,159	4,318	4,365	3,313	2,700
80	2,812	3,868	3,910	2,973	2,426	3,234	4,446	4,493	3,417	2,789
81	2,872	3,985	4,027	3,067	2,510	3,302	4,580	4,629	3,524	2,884
82	2,931	4,104	4,147	3,163	2,593	3,369	4,718	4,767	3,636	2,982
83	2,995	4,228	4,273	3,263	2,683	3,443	4,861	4,912	3,750	3,083
84	3,059	4,357	4,403	3,367	2,774	3,515	5,008	5,060	3,869	3,189
85	3,126	4,487	4,533	3,471	2,867	3,590	5,158	5,212	3,990	3,295
86	3,193	4,623	4,669	3,578	2,962	3,669	5,313	5,368	4,113	3,403
87	3,264	4,762	4,811	3,687	3,058	3,752	5,472	5,530	4,238	3,516
88	3,337	4,903	4,952	3,799	3,157	3,834	5,635	5,694	4,369	3,630
89	3,403	5,039	5,090	3,910	3,254	3,912	5,793	5,851	4,493	3,739
90	3,469	5,173	5,223	4,016	3,347	3,987	5,947	6,005	4,616	3,848
91	3,525	5,297	5,350	4,114	3,438	4,051	6,089	6,148	4,728	3,951
92	3,575	5,413	5,467	4,205	3,521	4,107	6,223	6,283	4,834	4,047
93	3,618	5,521	5,576	4,292	3,598	4,159	6,346	6,410	4,934	4,136
94	3,659	5,630	5,684	4,379	3,678	4,207	6,472	6,535	5,033	4,228
95	3,704	5,741	5,796	4,467	3,760	4,258	6,599	6,663	5,135	4,322
96	3,777	5,855	5,914	4,558	3,834	4,343	6,732	6,796	5,237	4,407
97	3,855	5,973	6,031	4,647	3,912	4,430	6,864	6,930	5,342	4,495
98	3,931	6,093	6,152	4,741	3,990	4,519	7,003	7,070	5,449	4,585
99	4,009	6,215	6,275	4,835	4,069	4,609	7,143	7,213	5,558	4,677

Premium payable other than annual will be determined according to the following factors:

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

There is a one-time $25.00 policy fee.
A discount factor of .88 is applied for household discount applicants

THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN OREGON ZIP CODES ALL EXCEPT
970-972

Attained Age	Female Plan A	Female Plan C	Female Plan F	Female Plan G	Female Plan N	Male Plan A	Male Plan C	Male Plan F	Male Plan G	Male Plan N
0-64	2,224	2,944	2,974	2,187	1,772	2,556	3,384	3,420	2,514	2,037
65	2,224	2,944	2,974	2,187	1,772	2,556	3,384	3,420	2,514	2,037
66	2,224	2,944	2,974	2,187	1,772	2,556	3,384	3,420	2,514	2,037
67	2,224	2,944	2,974	2,187	1,772	2,556	3,384	3,420	2,514	2,037
68	2,318	3,062	3,095	2,284	1,849	2,666	3,519	3,556	2,625	2,126
69	2,411	3,180	3,216	2,383	1,926	2,771	3,656	3,695	2,739	2,214
70	2,502	3,292	3,327	2,475	2,001	2,875	3,784	3,825	2,846	2,299
71	2,577	3,401	3,436	2,565	2,072	2,962	3,908	3,951	2,948	2,382
72	2,650	3,508	3,546	2,655	2,146	3,047	4,032	4,074	3,050	2,466
73	2,725	3,616	3,654	2,742	2,220	3,133	4,155	4,201	3,153	2,553
74	2,801	3,723	3,764	2,833	2,294	3,219	4,280	4,325	3,257	2,635
75	2,878	3,834	3,875	2,925	2,367	3,307	4,409	4,456	3,362	2,723
76	2,945	3,951	3,993	3,017	2,448	3,385	4,541	4,590	3,470	2,815
77	3,015	4,068	4,114	3,113	2,528	3,462	4,675	4,725	3,580	2,907
78	3,086	4,193	4,237	3,213	2,614	3,547	4,819	4,870	3,694	3,004
79	3,159	4,318	4,365	3,313	2,700	3,633	4,963	5,016	3,810	3,104
80	3,234	4,446	4,493	3,417	2,789	3,718	5,109	5,166	3,928	3,206
81	3,302	4,580	4,629	3,524	2,884	3,794	5,264	5,320	4,052	3,315
82	3,369	4,718	4,767	3,636	2,982	3,873	5,422	5,479	4,178	3,427
83	3,443	4,861	4,912	3,750	3,083	3,956	5,587	5,646	4,310	3,546
84	3,515	5,008	5,060	3,869	3,189	4,040	5,757	5,816	4,446	3,665
85	3,590	5,158	5,212	3,990	3,295	4,127	5,929	5,991	4,585	3,788
86	3,669	5,313	5,368	4,113	3,403	4,218	6,107	6,171	4,727	3,912
87	3,752	5,472	5,530	4,238	3,516	4,313	6,291	6,354	4,871	4,040
88	3,834	5,635	5,694	4,369	3,630	4,409	6,477	6,544	5,020	4,172
89	3,912	5,793	5,851	4,493	3,739	4,498	6,656	6,723	5,165	4,298
90	3,987	5,947	6,005	4,616	3,848	4,584	6,833	6,903	5,304	4,422
91	4,051	6,089	6,148	4,728	3,951	4,656	7,000	7,067	5,434	4,542
92	4,107	6,223	6,283	4,834	4,047	4,722	7,152	7,223	5,557	4,651
93	4,159	6,346	6,410	4,934	4,136	4,779	7,294	7,367	5,670	4,754
94	4,207	6,472	6,535	5,033	4,228	4,836	7,439	7,511	5,785	4,860
95	4,258	6,599	6,663	5,135	4,322	4,894	7,585	7,658	5,901	4,967
96	4,343	6,732	6,796	5,237	4,407	4,993	7,737	7,812	6,020	5,065
97	4,430	6,864	6,930	5,342	4,495	5,092	7,893	7,968	6,140	5,167
98	4,519	7,003	7,070	5,449	4,585	5,194	8,050	8,127	6,263	5,270
99	4,609	7,143	7,213	5,558	4,677	5,297	8,211	8,290	6,388	5,376

Premium payable other than annual will be determined according to the following factors:

Semi Annual	Quarterly	Monthly
1/2	**1/4**	**1/12**

There is a one-time $25.00 policy fee.
A discount factor of .88 is applied for household discount applicants

PREMIUM INFORMATION

The Manhattan Life Insurance Company may change your premium if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class on the date of change. Class is defined as attained age, underwriting class, and state of residence.

Premiums are based on your attained age and will change on Your Policy Anniversary Date.

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 The Manhattan Life Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to our Medicare Supplement Administrative Office at P. O. Box 925568, Houston, Texas 77292-5568. 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. Neither The Manhattan Life Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

LIMITATIONS AND EXCLUSIONS

This Policy does not pay expenses related to any coverage that is limited or excluded by Medicare related to serviced not "reasonable and Medically Necessary" under the Medicare Program Standards for diagnosis or treatment of Injury or Sickness.

REFUND OF PREMIUMS

The Policy does contain a Pro-Rata Refund provision which provides for the partial refund of premium upon death.

The Policy does contain a Cancellation By Insured provision which provides for a refund of premium upon surrender of the Policy.

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.

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

Please refer to your policy for details.

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 $1408	$0	$1408 (Part A deductible)
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $704 a day	$704 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:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 a day	$0	Up to $176 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

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

PLAN A

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

*Once you have been billed $198 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 $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $198 of Medicare Approved Amounts*	$0	$0	$198 (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 $1408	$1408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $704 a day	$704 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:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ 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 $198 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 $198 of Medicare Approved Amounts*	$0	$198 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $198 of Medicare Approved Amounts*	$0	$198 (Part B deductible)	$0
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 $198 of Medicare Approved Amounts*	$0	$198 (Part B deductible)	$0
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 lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum.

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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1408	$1408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $704 a day	$704 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:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ 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 F

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

*Once you have been billed $198 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 $198 of Medicare Approved Amounts*	$0	$198 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $198 of Medicare Approved amounts*	$0	$198 (Part B deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $198 of Medicare Approved Amounts*	$0	$198 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER SERVICES – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1408	$1408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $704 a day	$704 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:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ 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.

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

*Once you have been billed $198 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 $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	0%
BLOOD			
First 3 pints	$0	All costs	$0
Next $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 lifetime maximum benefit of $50,000.	20% and amounts over the $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 $1408	$1408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $704 a day	$704 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:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ 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 N

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

*Once you have been billed $198 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 $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B deductible)
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 co-payment 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 co-payment 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)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First $198 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $198 (Part B deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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.