

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

These charts show 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. The Manhattan Life Insurance Company offers five of the eleven plans available.

Plans E, H, I, and J are no longer available for sale.

**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 co-payments.

Blood: First three pints of blood each year.

Hospice: Part A coinsurance

A	B	C	D	F	F*	G	K	L	M	N
Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance*		Basic Benefits, including 100% Part B coinsurance	Hospitalization and preventative care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventative care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% 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			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit \$4620; paid at 100% after limit reached	Out-of-pocket limit \$2310; paid at 100% after limit reached		

\*Plans F also have an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2240 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2240. Out-of-pocket expenses for this deductible 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

**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	1,562	2,069	2,091	1,695	1,375	1,796	2,378	2,403	1,948	1,579
65	1,562	2,069	2,091	1,695	1,375	1,796	2,378	2,403	1,948	1,579
66	1,562	2,069	2,091	1,695	1,375	1,796	2,378	2,403	1,948	1,579
67	1,562	2,069	2,091	1,695	1,375	1,796	2,378	2,403	1,948	1,579
68	1,629	2,151	2,174	1,770	1,434	1,872	2,473	2,499	2,034	1,647
69	1,694	2,234	2,259	1,847	1,493	1,948	2,569	2,597	2,122	1,716
70	1,758	2,314	2,338	1,918	1,550	2,021	2,659	2,688	2,205	1,782
71	1,810	2,388	2,414	1,987	1,607	2,081	2,746	2,775	2,285	1,846
72	1,863	2,464	2,491	2,057	1,663	2,140	2,834	2,863	2,365	1,911
73	1,916	2,539	2,568	2,126	1,720	2,201	2,920	2,952	2,442	1,977
74	1,968	2,616	2,644	2,195	1,776	2,262	3,007	3,040	2,523	2,043
75	2,023	2,694	2,723	2,267	1,834	2,325	3,097	3,130	2,605	2,109
76	2,071	2,776	2,805	2,339	1,897	2,379	3,191	3,225	2,688	2,180
77	2,118	2,859	2,889	2,412	1,960	2,435	3,286	3,322	2,773	2,252
78	2,169	2,946	2,977	2,489	2,026	2,492	3,386	3,423	2,861	2,328
79	2,219	3,033	3,067	2,569	2,093	2,552	3,487	3,525	2,952	2,405
80	2,271	3,124	3,158	2,648	2,161	2,613	3,591	3,629	3,044	2,484
81	2,320	3,219	3,253	2,732	2,235	2,667	3,699	3,739	3,140	2,569
82	2,367	3,315	3,350	2,817	2,310	2,721	3,810	3,850	3,238	2,656
83	2,419	3,415	3,451	2,906	2,390	2,781	3,926	3,967	3,340	2,746
84	2,471	3,519	3,556	2,999	2,471	2,839	4,045	4,087	3,446	2,841
85	2,524	3,624	3,661	3,091	2,554	2,900	4,166	4,209	3,554	2,935
86	2,579	3,734	3,772	3,186	2,638	2,964	4,291	4,335	3,663	3,031
87	2,636	3,846	3,886	3,284	2,724	3,031	4,419	4,466	3,775	3,131
88	2,695	3,961	4,000	3,385	2,812	3,097	4,551	4,599	3,891	3,234
89	2,749	4,070	4,112	3,482	2,898	3,160	4,679	4,725	4,001	3,331
90	2,802	4,177	4,219	3,577	2,981	3,221	4,803	4,850	4,111	3,428
91	2,847	4,279	4,321	3,664	3,062	3,273	4,918	4,966	4,211	3,519
92	2,887	4,372	4,416	3,746	3,136	3,317	5,026	5,075	4,306	3,604
93	2,922	4,459	4,503	3,823	3,205	3,359	5,125	5,177	4,395	3,684
94	2,955	4,548	4,591	3,901	3,277	3,398	5,228	5,278	4,483	3,766
95	2,992	4,637	4,682	3,979	3,349	3,439	5,330	5,382	4,574	3,849
96	3,051	4,729	4,777	4,059	3,414	3,508	5,437	5,489	4,665	3,925
97	3,113	4,824	4,871	4,139	3,484	3,579	5,544	5,597	4,758	4,004
98	3,175	4,921	4,969	4,223	3,554	3,650	5,656	5,710	4,853	4,084
99	3,239	5,020	5,068	4,307	3,624	3,723	5,769	5,825	4,950	4,166

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

Semi Annual  
1/2

Quarterly  
1/4

Monthly  
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	1,796	2,378	2,403	1,948	1,579	2,064	2,733	2,763	2,239	1,815
65	1,796	2,378	2,403	1,948	1,579	2,064	2,733	2,763	2,239	1,815
66	1,796	2,378	2,403	1,948	1,579	2,064	2,733	2,763	2,239	1,815
67	1,796	2,378	2,403	1,948	1,579	2,064	2,733	2,763	2,239	1,815
68	1,872	2,473	2,499	2,034	1,647	2,153	2,842	2,872	2,338	1,893
69	1,948	2,569	2,597	2,122	1,716	2,238	2,953	2,985	2,440	1,972
70	2,021	2,659	2,688	2,205	1,782	2,322	3,056	3,089	2,535	2,047
71	2,081	2,746	2,775	2,285	1,846	2,392	3,156	3,191	2,626	2,121
72	2,140	2,834	2,863	2,365	1,911	2,461	3,257	3,291	2,717	2,196
73	2,201	2,920	2,952	2,442	1,977	2,530	3,355	3,392	2,808	2,273
74	2,262	3,007	3,040	2,523	2,043	2,600	3,456	3,493	2,900	2,347
75	2,325	3,097	3,130	2,605	2,109	2,671	3,561	3,599	2,994	2,424
76	2,379	3,191	3,225	2,688	2,180	2,734	3,668	3,707	3,090	2,507
77	2,435	3,286	3,322	2,773	2,252	2,797	3,776	3,816	3,188	2,589
78	2,492	3,386	3,423	2,861	2,328	2,864	3,892	3,933	3,290	2,675
79	2,552	3,487	3,525	2,952	2,405	2,934	4,008	4,051	3,393	2,765
80	2,613	3,591	3,629	3,044	2,484	3,003	4,127	4,172	3,499	2,856
81	2,667	3,699	3,739	3,140	2,569	3,065	4,252	4,297	3,609	2,953
82	2,721	3,810	3,850	3,238	2,656	3,128	4,380	4,425	3,721	3,052
83	2,781	3,926	3,967	3,340	2,746	3,195	4,513	4,560	3,839	3,158
84	2,839	4,045	4,087	3,446	2,841	3,263	4,649	4,698	3,961	3,264
85	2,900	4,166	4,209	3,554	2,935	3,334	4,789	4,838	4,084	3,373
86	2,964	4,291	4,335	3,663	3,031	3,407	4,932	4,984	4,210	3,485
87	3,031	4,419	4,466	3,775	3,131	3,484	5,081	5,132	4,339	3,599
88	3,097	4,551	4,599	3,891	3,234	3,561	5,232	5,285	4,472	3,716
89	3,160	4,679	4,725	4,001	3,331	3,633	5,376	5,430	4,600	3,829
90	3,221	4,803	4,850	4,111	3,428	3,701	5,519	5,576	4,724	3,940
91	3,273	4,918	4,966	4,211	3,519	3,761	5,653	5,709	4,840	4,045
92	3,317	5,026	5,075	4,306	3,604	3,814	5,776	5,834	4,950	4,143
93	3,359	5,125	5,177	4,395	3,684	3,860	5,891	5,950	5,050	4,235
94	3,398	5,228	5,278	4,483	3,766	3,906	6,008	6,067	5,153	4,329
95	3,439	5,330	5,382	4,574	3,849	3,953	6,126	6,185	5,256	4,424
96	3,508	5,437	5,489	4,665	3,925	4,033	6,249	6,310	5,362	4,512
97	3,579	5,544	5,597	4,758	4,004	4,113	6,375	6,435	5,469	4,603
98	3,650	5,656	5,710	4,853	4,084	4,195	6,502	6,564	5,578	4,694
99	3,723	5,769	5,825	4,950	4,166	4,279	6,632	6,696	5,690	4,789

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

Semi Annual  
1/2

Quarterly  
1/4

Monthly  
1/12

There is a one time \$25.00 policy fee.  
A discount factor of 0.88 is applied for household discount applicants

**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	1,463	1,938	1,959	1,588	1,288	1,683	2,228	2,251	1,825	1,479
65	1,463	1,938	1,959	1,588	1,288	1,683	2,228	2,251	1,825	1,479
66	1,463	1,938	1,959	1,588	1,288	1,683	2,228	2,251	1,825	1,479
67	1,463	1,938	1,959	1,588	1,288	1,683	2,228	2,251	1,825	1,479
68	1,526	2,015	2,036	1,658	1,343	1,754	2,317	2,342	1,905	1,543
69	1,587	2,093	2,116	1,730	1,399	1,825	2,407	2,433	1,988	1,607
70	1,647	2,168	2,190	1,797	1,452	1,893	2,491	2,518	2,066	1,670
71	1,695	2,237	2,261	1,862	1,506	1,949	2,573	2,600	2,140	1,729
72	1,745	2,309	2,334	1,927	1,558	2,005	2,655	2,682	2,215	1,791
73	1,795	2,379	2,406	1,992	1,611	2,062	2,736	2,765	2,288	1,852
74	1,844	2,451	2,477	2,056	1,663	2,119	2,817	2,848	2,364	1,914
75	1,895	2,524	2,551	2,124	1,719	2,178	2,901	2,933	2,440	1,976
76	1,940	2,601	2,628	2,191	1,777	2,229	2,990	3,022	2,518	2,043
77	1,984	2,678	2,706	2,260	1,836	2,281	3,079	3,112	2,598	2,110
78	2,032	2,760	2,789	2,332	1,898	2,334	3,172	3,207	2,681	2,181
79	2,079	2,842	2,873	2,407	1,961	2,391	3,267	3,303	2,765	2,253
80	2,128	2,926	2,958	2,480	2,025	2,448	3,364	3,400	2,852	2,327
81	2,173	3,015	3,047	2,560	2,094	2,498	3,466	3,503	2,941	2,407
82	2,218	3,105	3,138	2,639	2,164	2,549	3,570	3,607	3,033	2,488
83	2,266	3,200	3,233	2,723	2,239	2,605	3,678	3,717	3,129	2,573
84	2,315	3,297	3,331	2,810	2,315	2,659	3,790	3,829	3,228	2,661
85	2,365	3,395	3,430	2,896	2,392	2,717	3,903	3,944	3,329	2,749
86	2,416	3,498	3,533	2,985	2,472	2,777	4,020	4,061	3,432	2,840
87	2,470	3,603	3,640	3,077	2,552	2,839	4,140	4,184	3,537	2,933
88	2,525	3,710	3,747	3,171	2,634	2,901	4,264	4,308	3,645	3,030
89	2,576	3,813	3,852	3,262	2,715	2,960	4,383	4,427	3,749	3,120
90	2,625	3,913	3,952	3,351	2,793	3,017	4,500	4,543	3,851	3,211
91	2,667	4,009	4,048	3,433	2,868	3,066	4,608	4,652	3,945	3,297
92	2,705	4,096	4,137	3,509	2,938	3,108	4,708	4,754	4,034	3,377
93	2,738	4,178	4,219	3,581	3,003	3,147	4,802	4,850	4,117	3,451
94	2,769	4,260	4,301	3,654	3,070	3,184	4,898	4,945	4,200	3,528
95	2,803	4,344	4,386	3,727	3,137	3,222	4,994	5,042	4,285	3,606
96	2,859	4,430	4,475	3,803	3,199	3,287	5,093	5,142	4,370	3,677
97	2,917	4,519	4,563	3,878	3,264	3,353	5,194	5,244	4,457	3,751
98	2,974	4,610	4,655	3,956	3,329	3,419	5,299	5,350	4,546	3,826
99	3,034	4,703	4,748	4,035	3,395	3,488	5,405	5,457	4,638	3,903

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

Semi Annual  
1/2

Quarterly  
1/4

Monthly  
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					Male				
	Plan A	Plan C	Plan F	Plan G	Plan N	Plan A	Plan C	Plan F	Plan G	Plan N
0-64	1,683	2,228	2,251	1,825	1,479	1,934	2,561	2,588	2,098	1,700
65	1,683	2,228	2,251	1,825	1,479	1,934	2,561	2,588	2,098	1,700
66	1,683	2,228	2,251	1,825	1,479	1,934	2,561	2,588	2,098	1,700
67	1,683	2,228	2,251	1,825	1,479	1,934	2,561	2,588	2,098	1,700
68	1,754	2,317	2,342	1,905	1,543	2,017	2,663	2,690	2,190	1,774
69	1,825	2,407	2,433	1,988	1,607	2,097	2,766	2,796	2,286	1,848
70	1,893	2,491	2,518	2,066	1,670	2,175	2,863	2,894	2,375	1,918
71	1,949	2,573	2,600	2,140	1,729	2,241	2,957	2,990	2,460	1,987
72	2,005	2,655	2,682	2,215	1,791	2,306	3,051	3,083	2,545	2,058
73	2,062	2,736	2,765	2,288	1,852	2,370	3,143	3,178	2,631	2,130
74	2,119	2,817	2,848	2,364	1,914	2,436	3,238	3,273	2,717	2,199
75	2,178	2,901	2,933	2,440	1,976	2,503	3,336	3,371	2,805	2,271
76	2,229	2,990	3,022	2,518	2,043	2,561	3,436	3,473	2,895	2,349
77	2,281	3,079	3,112	2,598	2,110	2,620	3,538	3,575	2,987	2,425
78	2,334	3,172	3,207	2,681	2,181	2,683	3,646	3,685	3,082	2,506
79	2,391	3,267	3,303	2,765	2,253	2,748	3,755	3,795	3,179	2,590
80	2,448	3,364	3,400	2,852	2,327	2,813	3,866	3,909	3,278	2,675
81	2,498	3,466	3,503	2,941	2,407	2,871	3,984	4,025	3,381	2,766
82	2,549	3,570	3,607	3,033	2,488	2,931	4,103	4,146	3,486	2,860
83	2,605	3,678	3,717	3,129	2,573	2,993	4,228	4,272	3,596	2,958
84	2,659	3,790	3,829	3,228	2,661	3,057	4,356	4,401	3,710	3,058
85	2,717	3,903	3,944	3,329	2,749	3,123	4,486	4,533	3,826	3,160
86	2,777	4,020	4,061	3,432	2,840	3,192	4,621	4,669	3,944	3,265
87	2,839	4,140	4,184	3,537	2,933	3,264	4,760	4,808	4,065	3,371
88	2,901	4,264	4,308	3,645	3,030	3,336	4,901	4,951	4,189	3,482
89	2,960	4,383	4,427	3,749	3,120	3,403	5,037	5,087	4,309	3,587
90	3,017	4,500	4,543	3,851	3,211	3,467	5,170	5,223	4,426	3,691
91	3,066	4,608	4,652	3,945	3,297	3,524	5,296	5,348	4,535	3,790
92	3,108	4,708	4,754	4,034	3,377	3,573	5,411	5,465	4,637	3,881
93	3,147	4,802	4,850	4,117	3,451	3,616	5,519	5,574	4,731	3,968
94	3,184	4,898	4,945	4,200	3,528	3,660	5,628	5,684	4,827	4,056
95	3,222	4,994	5,042	4,285	3,606	3,703	5,739	5,795	4,924	4,145
96	3,287	5,093	5,142	4,370	3,677	3,778	5,854	5,911	5,023	4,227
97	3,353	5,194	5,244	4,457	3,751	3,853	5,972	6,029	5,124	4,312
98	3,419	5,299	5,350	4,546	3,826	3,930	6,091	6,149	5,226	4,397
99	3,488	5,405	5,457	4,638	3,903	4,009	6,213	6,273	5,330	4,486

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

Semi Annual  
1/2

Quarterly  
1/4

Monthly  
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.

## **DISCLOSURES**

Use this outline to compare benefits and premiums among policies.

**This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.**

## **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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1340 All but \$335 a day  All but \$670 a day  \$0  \$0	\$0 \$335 a day  \$670 a day  100% of Medicare eligible expenses  \$0	\$1340 (Part A deductible) \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$167.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$167.50 a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 \$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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , 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 deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1340 All but \$335 a day  All but \$670 a day  \$0  \$0	\$1340 (Part A deductible) \$335 a day  \$670 a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$167.50 a day \$0	\$0 Up to \$167.50 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 \$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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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	\$183 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$183 of Medicare Approved Amounts*	\$0	\$183 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment First \$183 of Medicare Approved Amounts*	\$0	\$183 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL –</b> <b>NOT COVERED BY MEDICARE</b> 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1340 All but \$335 a day  All but \$670 a day  \$0  \$0	\$1340 (Part A deductible) \$335 a day  \$670 a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$167.50 a day \$0	\$0 Up to \$167.50 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 \$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
<b>MEDICAL EXPENSES –</b> 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 Approved Amounts	\$0  Generally 80%	\$183 (Part B deductible)  Generally 20%	\$0  \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$183 of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 \$0 80%	All costs \$183 (Part B deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%  \$0 80%	\$0  \$183 (Part B deductible) 20%	\$0  \$0 \$0

**OTHER SERVICES – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> 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**

**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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1340 All but \$335 a day  All but \$670 a day  \$0  \$0	\$1340 (Part A deductible) \$335 a day  \$670 a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$167.50 a day \$0	\$0 Up to \$167.50 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 \$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
<b>MEDICAL EXPENSES –</b> 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 Approved Amounts	\$0  Generally 80%	\$0  Generally 20%	\$183 (Part B deductible)  \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	0%
<b>BLOOD</b> First 3 pints Next \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  \$0  80%	All costs  \$0  20%	\$0  \$183 (Part B deductible)  \$0
<b>CLINICAL LABORATORY</b> <b>SERVICES – TESTS FOR</b> <b>DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> <b>MEDICARE APPROVED</b> <b>SERVICES</b> — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%  \$0  80%	\$0  \$0  20%	\$0  \$183 (Part B deductible)  \$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>                      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</p>	<p>\$0                      \$0</p>	<p>\$0                      80% to a lifetime maximum benefit of \$50,000.</p>	<p>\$250                      20% and amounts over the \$50,000 lifetime maximum</p>

**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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1340 All but \$335 a day  All but \$670 a day  \$0  \$0	\$1340 (Part A deductible) \$335 a day  \$670 a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$167.50 a day \$0	\$0 Up to \$167.50 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 \$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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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 Approved Amounts	\$0  Generally 80%	\$0  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.	\$183 (Part B deductible)  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.
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$183 (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PLAN N**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> 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

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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.