ManhattanLife Assurance Company of America
Outline of Medicare Supplement Coverage-Cover Page
Benefit Plans A, 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. ManhattanLife Assurance Company of America offers four of the twelve plans available, Plans A, F, G, and N.

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 2022[2]						$6,620[2]	$3,310[2]					

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,490 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.

ManhattanLife Assurance Company of America
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN OREGON ZIP CODES
970-972

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	1,762	1,865	1,543	1,241	1,939	2,051	1,697	1,365
65	1,762	1,865	1,543	1,241	1,939	2,051	1,697	1,365
66	1,762	1,865	1,543	1,241	1,939	2,051	1,697	1,365
67	1,762	1,865	1,543	1,241	1,939	2,051	1,697	1,365
68	1,801	2,034	1,619	1,313	1,981	2,237	1,780	1,445
69	1,864	2,128	1,697	1,367	2,050	2,340	1,867	1,503
70	1,930	2,212	1,754	1,418	2,122	2,434	1,930	1,561
71	1,987	2,295	1,826	1,478	2,186	2,525	2,009	1,625
72	2,045	2,378	1,898	1,537	2,249	2,615	2,088	1,691
73	2,102	2,466	1,971	1,597	2,313	2,713	2,168	1,757
74	2,182	2,556	2,045	1,656	2,400	2,812	2,249	1,822
75	2,273	2,651	2,129	1,715	2,501	2,916	2,343	1,887
76	2,350	2,734	2,201	1,770	2,585	3,008	2,420	1,948
77	2,430	2,824	2,277	1,835	2,673	3,107	2,505	2,019
78	2,516	2,920	2,358	1,900	2,767	3,212	2,594	2,091
79	2,608	3,018	2,441	1,976	2,869	3,319	2,685	2,174
80	2,707	3,118	2,525	2,055	2,977	3,429	2,778	2,260
81	2,801	3,218	2,611	2,134	3,081	3,540	2,872	2,347
82	2,901	3,322	2,698	2,215	3,191	3,654	2,968	2,436
83	3,007	3,427	2,788	2,287	3,308	3,770	3,067	2,516
84	3,120	3,535	2,880	2,360	3,433	3,889	3,168	2,596
85	3,240	3,628	2,959	2,434	3,564	3,991	3,255	2,677
86	3,354	3,687	3,011	2,482	3,690	4,056	3,311	2,731
87	3,477	3,729	3,047	2,519	3,824	4,101	3,352	2,770
88	3,606	3,770	3,083	2,555	3,966	4,147	3,392	2,811
89	3,744	3,812	3,120	2,592	4,118	4,193	3,432	2,851
90	3,872	3,853	3,156	2,628	4,259	4,238	3,472	2,892
91	3,984	3,885	3,185	2,658	4,382	4,274	3,504	2,923
92	4,100	3,918	3,214	2,687	4,510	4,310	3,535	2,955
93	4,202	3,950	3,243	2,715	4,622	4,345	3,567	2,986
94	4,303	3,983	3,271	2,744	4,733	4,381	3,598	3,019
95	4,402	4,016	3,299	2,773	4,842	4,417	3,630	3,050
96	4,494	4,016	3,299	2,773	4,944	4,417	3,630	3,050
97	4,584	4,016	3,299	2,773	5,043	4,417	3,630	3,050
98	4,671	4,016	3,299	2,773	5,138	4,417	3,630	3,050
99	4,756	4,016	3,299	2,773	5,231	4,417	3,630	3,050

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 .93 is applied for household discount applicants

ManhattanLife Assurance Company of America
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN OREGON ZIP CODES
970-972

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	2,027	2,144	1,774	1,427	2,229	2,359	1,951	1,571
65	2,027	2,144	1,774	1,427	2,229	2,359	1,951	1,571
66	2,027	2,144	1,774	1,427	2,229	2,359	1,951	1,571
67	2,027	2,144	1,774	1,427	2,229	2,359	1,951	1,571
68	2,071	2,340	1,861	1,510	2,278	2,573	2,048	1,661
69	2,143	2,447	1,952	1,571	2,358	2,691	2,147	1,729
70	2,219	2,544	2,018	1,632	2,441	2,799	2,219	1,795
71	2,285	2,639	2,100	1,700	2,514	2,903	2,309	1,869
72	2,352	2,734	2,183	1,769	2,587	3,008	2,401	1,945
73	2,417	2,836	2,267	1,836	2,660	3,119	2,493	2,020
74	2,509	2,939	2,352	1,904	2,760	3,233	2,587	2,095
75	2,615	3,048	2,449	1,973	2,876	3,353	2,694	2,170
76	2,702	3,144	2,531	2,036	2,972	3,459	2,784	2,239
77	2,795	3,248	2,619	2,110	3,074	3,573	2,881	2,321
78	2,893	3,358	2,712	2,185	3,182	3,694	2,983	2,404
79	3,000	3,470	2,807	2,273	3,299	3,817	3,088	2,500
80	3,113	3,585	2,904	2,363	3,425	3,944	3,195	2,599
81	3,221	3,701	3,002	2,454	3,543	4,071	3,303	2,699
82	3,336	3,820	3,103	2,547	3,669	4,202	3,414	2,802
83	3,459	3,941	3,207	2,630	3,804	4,335	3,527	2,893
84	3,588	4,065	3,312	2,714	3,947	4,472	3,643	2,984
85	3,726	4,172	3,403	2,798	4,100	4,589	3,743	3,078
86	3,858	4,240	3,462	2,855	4,244	4,665	3,808	3,140
87	3,998	4,288	3,504	2,896	4,397	4,717	3,855	3,186
88	4,146	4,335	3,546	2,939	4,561	4,769	3,901	3,233
89	4,306	4,383	3,587	2,981	4,736	4,821	3,947	3,279
90	4,452	4,431	3,630	3,023	4,898	4,874	3,992	3,325
91	4,582	4,469	3,663	3,056	5,040	4,915	4,029	3,362
92	4,714	4,505	3,695	3,089	5,186	4,956	4,065	3,398
93	4,832	4,543	3,729	3,122	5,315	4,998	4,101	3,434
94	4,948	4,580	3,762	3,155	5,443	5,038	4,137	3,471
95	5,062	4,618	3,794	3,189	5,568	5,080	4,174	3,507
96	5,168	4,618	3,794	3,189	5,685	5,080	4,174	3,507
97	5,271	4,618	3,794	3,189	5,799	5,080	4,174	3,507
98	5,372	4,618	3,794	3,189	5,909	5,080	4,174	3,507
99	5,468	4,618	3,794	3,189	6,016	5,080	4,174	3,507

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 .93 is applied for household discount applicants

ManhattanLife Assurance Company of America
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN OREGON ZIP CODES
973-979

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	1,664	1,761	1,457	1,172	1,831	1,937	1,602	1,289
65	1,664	1,761	1,457	1,172	1,831	1,937	1,602	1,289
66	1,664	1,761	1,457	1,172	1,831	1,937	1,602	1,289
67	1,664	1,761	1,457	1,172	1,831	1,937	1,602	1,289
68	1,701	1,921	1,529	1,240	1,871	2,113	1,681	1,364
69	1,760	2,009	1,603	1,291	1,936	2,210	1,763	1,420
70	1,822	2,089	1,657	1,340	2,004	2,298	1,822	1,474
71	1,877	2,168	1,725	1,396	2,065	2,384	1,897	1,535
72	1,931	2,246	1,793	1,452	2,124	2,470	1,972	1,597
73	1,986	2,329	1,862	1,508	2,185	2,562	2,048	1,659
74	2,060	2,414	1,931	1,564	2,267	2,655	2,124	1,720
75	2,147	2,503	2,011	1,620	2,362	2,754	2,213	1,782
76	2,219	2,582	2,078	1,672	2,441	2,841	2,286	1,839
77	2,295	2,667	2,151	1,733	2,525	2,934	2,366	1,907
78	2,376	2,757	2,227	1,794	2,613	3,034	2,450	1,975
79	2,463	2,850	2,305	1,867	2,710	3,135	2,536	2,054
80	2,557	2,944	2,385	1,941	2,812	3,239	2,624	2,134
81	2,645	3,040	2,466	2,015	2,910	3,343	2,712	2,217
82	2,740	3,137	2,548	2,092	3,014	3,451	2,803	2,301
83	2,840	3,237	2,633	2,160	3,124	3,561	2,897	2,376
84	2,947	3,339	2,720	2,229	3,242	3,673	2,992	2,451
85	3,060	3,426	2,795	2,298	3,366	3,769	3,074	2,528
86	3,168	3,482	2,843	2,344	3,485	3,831	3,127	2,579
87	3,284	3,522	2,877	2,379	3,612	3,873	3,165	2,616
88	3,406	3,561	2,912	2,413	3,746	3,917	3,204	2,655
89	3,536	3,600	2,947	2,448	3,890	3,960	3,241	2,693
90	3,657	3,639	2,981	2,482	4,022	4,003	3,279	2,731
91	3,763	3,669	3,008	2,510	4,139	4,037	3,309	2,761
92	3,872	3,700	3,035	2,537	4,259	4,071	3,339	2,791
93	3,969	3,731	3,063	2,564	4,366	4,104	3,369	2,820
94	4,064	3,762	3,089	2,592	4,470	4,138	3,398	2,851
95	4,157	3,793	3,116	2,619	4,573	4,172	3,428	2,881
96	4,244	3,793	3,116	2,619	4,669	4,172	3,428	2,881
97	4,329	3,793	3,116	2,619	4,763	4,172	3,428	2,881
98	4,412	3,793	3,116	2,619	4,853	4,172	3,428	2,881
99	4,491	3,793	3,116	2,619	4,940	4,172	3,428	2,881

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 .93 is applied for household discount applicants

ManhattanLife Assurance Company of America
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN OREGON ZIP CODES
973-979

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	1,914	2,025	1,675	1,348	2,105	2,228	1,843	1,483
65	1,914	2,025	1,675	1,348	2,105	2,228	1,843	1,483
66	1,914	2,025	1,675	1,348	2,105	2,228	1,843	1,483
67	1,914	2,025	1,675	1,348	2,105	2,228	1,843	1,483
68	1,956	2,210	1,758	1,426	2,151	2,430	1,934	1,569
69	2,024	2,311	1,844	1,484	2,227	2,542	2,028	1,633
70	2,095	2,403	1,906	1,541	2,305	2,644	2,096	1,695
71	2,158	2,492	1,983	1,606	2,374	2,741	2,181	1,765
72	2,221	2,582	2,061	1,670	2,443	2,841	2,268	1,837
73	2,283	2,678	2,141	1,734	2,512	2,946	2,355	1,907
74	2,370	2,776	2,221	1,799	2,607	3,053	2,443	1,979
75	2,469	2,879	2,313	1,863	2,717	3,167	2,544	2,049
76	2,552	2,969	2,390	1,923	2,807	3,267	2,629	2,115
77	2,639	3,068	2,474	1,992	2,903	3,375	2,721	2,192
78	2,732	3,171	2,561	2,064	3,005	3,488	2,817	2,270
79	2,833	3,278	2,651	2,147	3,116	3,605	2,916	2,361
80	2,940	3,386	2,743	2,232	3,234	3,725	3,018	2,455
81	3,042	3,495	2,836	2,318	3,346	3,845	3,120	2,549
82	3,151	3,607	2,931	2,406	3,465	3,969	3,224	2,646
83	3,267	3,722	3,029	2,484	3,593	4,094	3,331	2,732
84	3,389	3,839	3,128	2,563	3,728	4,224	3,441	2,819
85	3,519	3,940	3,214	2,643	3,872	4,334	3,535	2,907
86	3,644	4,004	3,270	2,696	4,008	4,406	3,596	2,966
87	3,776	4,049	3,309	2,735	4,153	4,455	3,641	3,009
88	3,916	4,094	3,349	2,775	4,308	4,504	3,684	3,053
89	4,066	4,140	3,388	2,815	4,473	4,553	3,727	3,097
90	4,205	4,185	3,428	2,855	4,626	4,604	3,771	3,140
91	4,327	4,220	3,460	2,886	4,760	4,642	3,805	3,175
92	4,452	4,255	3,490	2,917	4,898	4,681	3,839	3,209
93	4,564	4,291	3,522	2,949	5,020	4,720	3,873	3,244
94	4,673	4,326	3,553	2,980	5,141	4,758	3,907	3,278
95	4,780	4,361	3,584	3,012	5,259	4,797	3,942	3,312
96	4,881	4,361	3,584	3,012	5,369	4,797	3,942	3,312
97	4,978	4,361	3,584	3,012	5,477	4,797	3,942	3,312
98	5,074	4,361	3,584	3,012	5,580	4,797	3,942	3,312
99	5,165	4,361	3,584	3,012	5,681	4,797	3,942	3,312

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 .93 is applied for household discount applicants

PREMIUM INFORMATION

ManhattanLife Assurance Company of America 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.

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 ManhattanLife Assurance Company of America.

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 ManhattanLife Assurance Company of America 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 services 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 $1556	$0	$1556 (Part A deductible)
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	$0	Up to $194.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	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 $233 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 $233 of Medicare Approved Amounts*	$0	$0	$233 (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 $233 of Medicare Approved Amounts*	$0	$0	$233 (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 $233 of Medicare Approved Amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

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 $1556	$1556 (Part A deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's 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 $233 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 $233 of Medicare Approved Amounts*	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$233 (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 $233 of Medicare Approved Amounts*	$0	$233 (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 $1556	$1556 (Part A deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's 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 G

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

*Once you have been billed $233 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 $233 of Medicare Approved Amounts*	$0	$0	$233 (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 $233 of Medicare Approved Amounts*	$0	$0	$233 (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 $233 of Medicare Approved Amounts*	$0	$0	$233 (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 $1556	$1556 (Part A deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's 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 $233 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 $233 of Medicare Approved Amounts*	$0	$0	$233 (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 $233 of Medicare Approved Amounts*	$0	$0	$233 (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 $233 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $233 (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.