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. 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 2020[2]						$5,880[2]	$2,940[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.

ManhattanLife Assurance Company of America
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN TEXAS ZIP CODES
770-773, 775

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	6,401	N/A	N/A	N/A	7,361	N/A	N/A	N/A
65	1,422	1,746	1,436	1,133	1,636	2,009	1,652	1,302
66	1,422	1,746	1,436	1,133	1,636	2,009	1,652	1,302
67	1,422	1,746	1,436	1,133	1,636	2,009	1,652	1,302
68	1,426	1,779	1,441	1,163	1,639	2,046	1,657	1,338
69	1,473	1,838	1,487	1,199	1,693	2,114	1,711	1,378
70	1,522	1,898	1,538	1,236	1,751	2,183	1,768	1,420
71	1,574	1,959	1,589	1,287	1,809	2,253	1,827	1,480
72	1,628	2,020	1,644	1,339	1,872	2,322	1,890	1,540
73	1,682	2,080	1,699	1,390	1,933	2,392	1,954	1,599
74	1,744	2,162	1,761	1,449	2,006	2,486	2,026	1,666
75	1,817	2,257	1,835	1,516	2,089	2,595	2,110	1,744
76	1,882	2,346	1,902	1,572	2,165	2,698	2,187	1,809
77	1,960	2,441	1,980	1,630	2,254	2,807	2,277	1,874
78	2,046	2,540	2,066	1,688	2,352	2,921	2,376	1,941
79	2,141	2,648	2,162	1,747	2,461	3,046	2,486	2,009
80	2,245	2,763	2,268	1,817	2,582	3,177	2,608	2,089
81	2,360	2,884	2,384	1,914	2,714	3,316	2,741	2,201
82	2,485	3,011	2,510	2,020	2,858	3,462	2,887	2,323
83	2,620	3,147	2,647	2,135	3,013	3,619	3,045	2,455
84	2,768	3,291	2,796	2,259	3,183	3,784	3,215	2,598
85	2,929	3,444	2,958	2,395	3,367	3,960	3,402	2,754
86	3,083	3,591	3,115	2,528	3,546	4,130	3,581	2,907
87	3,245	3,748	3,278	2,668	3,732	4,309	3,770	3,068
88	3,408	3,914	3,443	2,809	3,920	4,501	3,960	3,231
89	3,574	4,091	3,609	2,953	4,109	4,706	4,152	3,396
90	3,738	4,261	3,776	3,095	4,298	4,899	4,343	3,560
91	3,892	4,416	3,932	3,230	4,477	5,079	4,522	3,714
92	4,046	4,578	4,087	3,363	4,653	5,265	4,699	3,867
93	4,196	4,727	4,238	3,494	4,825	5,436	4,874	4,019
94	4,343	4,875	4,387	3,623	4,995	5,606	5,045	4,167
95	4,486	5,023	4,532	3,749	5,159	5,777	5,211	4,311
96	4,585	5,129	4,631	3,832	5,273	5,898	5,327	4,406
97	4,676	5,232	4,724	3,909	5,378	6,016	5,432	4,495
98	4,766	5,331	4,814	3,982	5,480	6,130	5,536	4,580
99	4,851	5,427	4,900	4,054	5,579	6,240	5,635	4,662

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 TEXAS ZIP CODES
770-773, 775

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	7,361	N/A	N/A	N/A	8,465	N/A	N/A	N/A
65	1,636	2,009	1,652	1,302	1,881	2,310	1,900	1,498
66	1,636	2,009	1,652	1,302	1,881	2,310	1,900	1,498
67	1,636	2,009	1,652	1,302	1,881	2,310	1,900	1,498
68	1,639	2,046	1,657	1,338	1,886	2,352	1,905	1,538
69	1,693	2,114	1,711	1,378	1,947	2,431	1,968	1,584
70	1,751	2,183	1,768	1,420	2,013	2,510	2,034	1,634
71	1,809	2,253	1,827	1,480	2,081	2,590	2,102	1,702
72	1,872	2,322	1,890	1,540	2,152	2,671	2,174	1,770
73	1,933	2,392	1,954	1,599	2,224	2,751	2,246	1,839
74	2,006	2,486	2,026	1,666	2,307	2,860	2,330	1,917
75	2,089	2,595	2,110	1,744	2,403	2,985	2,427	2,006
76	2,165	2,698	2,187	1,809	2,489	3,103	2,515	2,080
77	2,254	2,807	2,277	1,874	2,592	3,227	2,618	2,156
78	2,352	2,921	2,376	1,941	2,705	3,360	2,732	2,232
79	2,461	3,046	2,486	2,009	2,831	3,502	2,859	2,310
80	2,582	3,177	2,608	2,089	2,969	3,655	2,999	2,402
81	2,714	3,316	2,741	2,201	3,121	3,813	3,153	2,532
82	2,858	3,462	2,887	2,323	3,286	3,982	3,320	2,671
83	3,013	3,619	3,045	2,455	3,466	4,161	3,500	2,823
84	3,183	3,784	3,215	2,598	3,661	4,352	3,698	2,988
85	3,367	3,960	3,402	2,754	3,873	4,554	3,912	3,168
86	3,546	4,130	3,581	2,907	4,077	4,749	4,119	3,344
87	3,732	4,309	3,770	3,068	4,292	4,956	4,335	3,528
88	3,920	4,501	3,960	3,231	4,508	5,176	4,554	3,715
89	4,109	4,706	4,152	3,396	4,726	5,411	4,774	3,904
90	4,298	4,899	4,343	3,560	4,944	5,634	4,994	4,094
91	4,477	5,079	4,522	3,714	5,148	5,841	5,200	4,271
92	4,653	5,265	4,699	3,867	5,350	6,054	5,404	4,447
93	4,825	5,436	4,874	4,019	5,549	6,251	5,605	4,621
94	4,995	5,606	5,045	4,167	5,743	6,448	5,802	4,792
95	5,159	5,777	5,211	4,311	5,934	6,643	5,993	4,958
96	5,273	5,898	5,327	4,406	6,064	6,782	6,125	5,067
97	5,378	6,016	5,432	4,495	6,185	6,918	6,248	5,169
98	5,480	6,130	5,536	4,580	6,303	7,050	6,367	5,267
99	5,579	6,240	5,635	4,662	6,416	7,177	6,481	5,361

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 TEXAS ZIP CODES
750-753, 760, 761, 774, 776, 777, 782, 784, 793, 794

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	5,749	N/A	N/A	N/A	6,612	N/A	N/A	N/A
65	1,277	1,568	1,290	1,018	1,470	1,804	1,484	1,170
66	1,277	1,568	1,290	1,018	1,470	1,804	1,484	1,170
67	1,277	1,568	1,290	1,018	1,470	1,804	1,484	1,170
68	1,280	1,598	1,294	1,045	1,472	1,837	1,488	1,202
69	1,323	1,651	1,336	1,077	1,521	1,898	1,536	1,238
70	1,367	1,704	1,381	1,110	1,572	1,960	1,588	1,276
71	1,413	1,760	1,427	1,156	1,625	2,023	1,641	1,329
72	1,462	1,814	1,476	1,203	1,681	2,086	1,698	1,383
73	1,510	1,868	1,526	1,248	1,736	2,149	1,755	1,437
74	1,567	1,942	1,582	1,302	1,801	2,233	1,820	1,497
75	1,632	2,027	1,648	1,362	1,876	2,331	1,895	1,567
76	1,691	2,107	1,708	1,412	1,945	2,423	1,964	1,625
77	1,761	2,192	1,778	1,464	2,024	2,521	2,045	1,683
78	1,837	2,281	1,856	1,516	2,113	2,624	2,134	1,743
79	1,923	2,378	1,942	1,569	2,211	2,735	2,233	1,804
80	2,017	2,481	2,037	1,632	2,319	2,854	2,343	1,876
81	2,119	2,590	2,141	1,719	2,438	2,978	2,462	1,977
82	2,232	2,704	2,254	1,814	2,567	3,110	2,593	2,086
83	2,353	2,827	2,377	1,918	2,706	3,250	2,734	2,205
84	2,486	2,956	2,511	2,029	2,859	3,399	2,888	2,334
85	2,631	3,093	2,657	2,151	3,024	3,557	3,056	2,474
86	2,769	3,225	2,797	2,271	3,185	3,709	3,217	2,611
87	2,915	3,366	2,944	2,396	3,352	3,870	3,386	2,756
88	3,061	3,515	3,092	2,523	3,521	4,043	3,557	2,902
89	3,210	3,674	3,242	2,652	3,691	4,226	3,729	3,050
90	3,357	3,827	3,391	2,780	3,861	4,400	3,900	3,197
91	3,496	3,966	3,532	2,901	4,021	4,562	4,061	3,336
92	3,634	4,112	3,670	3,021	4,179	4,729	4,220	3,474
93	3,768	4,246	3,806	3,138	4,334	4,882	4,378	3,609
94	3,900	4,379	3,940	3,254	4,486	5,035	4,531	3,742
95	4,029	4,511	4,070	3,367	4,634	5,189	4,680	3,872
96	4,118	4,607	4,159	3,442	4,736	5,297	4,784	3,958
97	4,200	4,699	4,243	3,510	4,831	5,403	4,879	4,037
98	4,281	4,788	4,323	3,576	4,922	5,506	4,972	4,114
99	4,357	4,874	4,401	3,641	5,011	5,605	5,061	4,187

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 TEXAS ZIP CODES
750-753, 760, 761, 774, 776, 777, 782, 784, 793, 794

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	6,612	N/A	N/A	N/A	7,603	N/A	N/A	N/A
65	1,470	1,804	1,484	1,170	1,690	2,075	1,706	1,345
66	1,470	1,804	1,484	1,170	1,690	2,075	1,706	1,345
67	1,470	1,804	1,484	1,170	1,690	2,075	1,706	1,345
68	1,472	1,837	1,488	1,202	1,694	2,113	1,711	1,381
69	1,521	1,898	1,536	1,238	1,749	2,183	1,767	1,423
70	1,572	1,960	1,588	1,276	1,808	2,254	1,827	1,468
71	1,625	2,023	1,641	1,329	1,869	2,326	1,888	1,529
72	1,681	2,086	1,698	1,383	1,933	2,399	1,953	1,590
73	1,736	2,149	1,755	1,437	1,997	2,471	2,018	1,652
74	1,801	2,233	1,820	1,497	2,072	2,569	2,092	1,722
75	1,876	2,331	1,895	1,567	2,158	2,681	2,180	1,801
76	1,945	2,423	1,964	1,625	2,236	2,787	2,259	1,868
77	2,024	2,521	2,045	1,683	2,328	2,898	2,351	1,936
78	2,113	2,624	2,134	1,743	2,430	3,018	2,454	2,005
79	2,211	2,735	2,233	1,804	2,542	3,146	2,568	2,075
80	2,319	2,854	2,343	1,876	2,667	3,282	2,694	2,157
81	2,438	2,978	2,462	1,977	2,803	3,425	2,831	2,274
82	2,567	3,110	2,593	2,086	2,952	3,576	2,982	2,399
83	2,706	3,250	2,734	2,205	3,113	3,737	3,144	2,536
84	2,859	3,399	2,888	2,334	3,288	3,909	3,321	2,684
85	3,024	3,557	3,056	2,474	3,478	4,090	3,513	2,845
86	3,185	3,709	3,217	2,611	3,662	4,265	3,700	3,003
87	3,352	3,870	3,386	2,756	3,855	4,451	3,894	3,169
88	3,521	4,043	3,557	2,902	4,049	4,649	4,090	3,337
89	3,691	4,226	3,729	3,050	4,245	4,860	4,287	3,507
90	3,861	4,400	3,900	3,197	4,441	5,060	4,485	3,677
91	4,021	4,562	4,061	3,336	4,624	5,246	4,671	3,836
92	4,179	4,729	4,220	3,474	4,805	5,438	4,854	3,994
93	4,334	4,882	4,378	3,609	4,984	5,614	5,034	4,151
94	4,486	5,035	4,531	3,742	5,158	5,791	5,211	4,304
95	4,634	5,189	4,680	3,872	5,329	5,966	5,383	4,453
96	4,736	5,297	4,784	3,958	5,447	6,092	5,501	4,551
97	4,831	5,403	4,879	4,037	5,555	6,214	5,611	4,642
98	4,922	5,506	4,972	4,114	5,661	6,332	5,718	4,731
99	5,011	5,605	5,061	4,187	5,763	6,446	5,821	4,815

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 TEXAS ZIP CODES ALL EXCEPT
750-753, 760, 761, 770-777, 782, 784, 793, 794

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	5,097	N/A	N/A	N/A	5,862	N/A	N/A	N/A
65	1,133	1,391	1,144	902	1,303	1,600	1,316	1,037
66	1,133	1,391	1,144	902	1,303	1,600	1,316	1,037
67	1,133	1,391	1,144	902	1,303	1,600	1,316	1,037
68	1,135	1,416	1,147	926	1,305	1,629	1,319	1,066
69	1,173	1,464	1,184	955	1,348	1,683	1,362	1,097
70	1,212	1,511	1,225	984	1,394	1,738	1,408	1,131
71	1,253	1,560	1,265	1,025	1,441	1,794	1,455	1,178
72	1,296	1,608	1,309	1,066	1,490	1,849	1,505	1,226
73	1,339	1,656	1,353	1,107	1,539	1,905	1,556	1,274
74	1,389	1,722	1,403	1,154	1,597	1,980	1,613	1,327
75	1,447	1,797	1,461	1,207	1,663	2,067	1,680	1,389
76	1,499	1,868	1,514	1,252	1,724	2,148	1,742	1,441
77	1,561	1,944	1,576	1,298	1,795	2,235	1,813	1,492
78	1,629	2,023	1,645	1,344	1,873	2,326	1,892	1,545
79	1,705	2,109	1,722	1,391	1,960	2,425	1,980	1,600
80	1,788	2,200	1,806	1,447	2,056	2,530	2,077	1,663
81	1,879	2,296	1,898	1,524	2,161	2,640	2,183	1,753
82	1,979	2,398	1,999	1,608	2,276	2,757	2,299	1,850
83	2,086	2,506	2,108	1,700	2,399	2,882	2,424	1,955
84	2,204	2,620	2,227	1,799	2,534	3,013	2,560	2,069
85	2,332	2,743	2,356	1,907	2,681	3,154	2,709	2,193
86	2,455	2,860	2,480	2,013	2,823	3,289	2,852	2,315
87	2,584	2,984	2,610	2,124	2,972	3,431	3,002	2,443
88	2,714	3,117	2,742	2,237	3,122	3,584	3,154	2,573
89	2,846	3,258	2,874	2,351	3,272	3,747	3,306	2,704
90	2,976	3,393	3,007	2,465	3,423	3,901	3,458	2,835
91	3,099	3,517	3,131	2,572	3,565	4,045	3,601	2,958
92	3,222	3,646	3,254	2,678	3,705	4,193	3,742	3,080
93	3,341	3,764	3,375	2,782	3,842	4,328	3,881	3,200
94	3,458	3,882	3,493	2,885	3,978	4,464	4,017	3,318
95	3,572	4,000	3,609	2,985	4,108	4,600	4,150	3,433
96	3,651	4,084	3,688	3,051	4,199	4,696	4,242	3,509
97	3,724	4,166	3,762	3,112	4,283	4,790	4,326	3,579
98	3,795	4,245	3,833	3,171	4,364	4,881	4,408	3,647
99	3,863	4,322	3,902	3,228	4,443	4,969	4,487	3,713

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 TEXAS ZIP CODES ALL EXCEPT
750-753, 760, 761, 770-777, 782, 784, 793, 794

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	5,862	N/A	N/A	N/A	6,741	N/A	N/A	N/A
65	1,303	1,600	1,316	1,037	1,498	1,840	1,513	1,193
66	1,303	1,600	1,316	1,037	1,498	1,840	1,513	1,193
67	1,303	1,600	1,316	1,037	1,498	1,840	1,513	1,193
68	1,305	1,629	1,319	1,066	1,502	1,873	1,517	1,225
69	1,348	1,683	1,362	1,097	1,551	1,936	1,567	1,262
70	1,394	1,738	1,408	1,131	1,603	1,999	1,619	1,301
71	1,441	1,794	1,455	1,178	1,657	2,062	1,674	1,355
72	1,490	1,849	1,505	1,226	1,714	2,127	1,731	1,410
73	1,539	1,905	1,556	1,274	1,771	2,190	1,789	1,465
74	1,597	1,980	1,613	1,327	1,837	2,277	1,855	1,527
75	1,663	2,067	1,680	1,389	1,914	2,377	1,932	1,597
76	1,724	2,148	1,742	1,441	1,982	2,471	2,003	1,656
77	1,795	2,235	1,813	1,492	2,064	2,570	2,085	1,717
78	1,873	2,326	1,892	1,545	2,154	2,675	2,176	1,778
79	1,960	2,425	1,980	1,600	2,254	2,789	2,276	1,840
80	2,056	2,530	2,077	1,663	2,364	2,910	2,388	1,913
81	2,161	2,640	2,183	1,753	2,485	3,037	2,510	2,016
82	2,276	2,757	2,299	1,850	2,617	3,171	2,644	2,127
83	2,399	2,882	2,424	1,955	2,760	3,314	2,787	2,248
84	2,534	3,013	2,560	2,069	2,915	3,466	2,945	2,380
85	2,681	3,154	2,709	2,193	3,084	3,627	3,115	2,522
86	2,823	3,289	2,852	2,315	3,247	3,781	3,280	2,663
87	2,972	3,431	3,002	2,443	3,418	3,947	3,452	2,810
88	3,122	3,584	3,154	2,573	3,590	4,122	3,627	2,958
89	3,272	3,747	3,306	2,704	3,763	4,309	3,801	3,109
90	3,423	3,901	3,458	2,835	3,937	4,487	3,977	3,260
91	3,565	4,045	3,601	2,958	4,100	4,651	4,141	3,401
92	3,705	4,193	3,742	3,080	4,260	4,821	4,303	3,541
93	3,842	4,328	3,881	3,200	4,419	4,978	4,463	3,680
94	3,978	4,464	4,017	3,318	4,573	5,134	4,620	3,816
95	4,108	4,600	4,150	3,433	4,725	5,290	4,772	3,948
96	4,199	4,696	4,242	3,509	4,829	5,401	4,877	4,035
97	4,283	4,790	4,326	3,579	4,925	5,509	4,975	4,116
98	4,364	4,881	4,408	3,647	5,019	5,614	5,070	4,194
99	4,443	4,969	4,487	3,713	5,109	5,715	5,161	4,269

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 onetime $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, and if such rate increase is approved by the Texas Department of Insurance. 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 household discount for qualified household discount applicants, 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

We will not pay benefits for:

(a) expense incurred while this Policy is not in force, except as provided in the Extension of Benefits section;

(b) We will not pay benefits for hospital or skilled nursing facility charges incurred while this policy is not in force.

(c) that portion of any expense incurred which is paid for by Medicare;

(d) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take home drugs and eye refractions;

(e) services for which a charge is not normally made in the absence of insurance; or

(f) loss or expense that is payable under any other Medicare Supplement Insurance Policy or certificate.

REFUND OF PREMIUMS

The Policy does contain a Pro-Rata Refund provision which provides for the refund of that part of any premium You have paid which covers the period after the death occurs.

The Policy does contain a Cancellation By Insured provision which provides for a pro-rata refund of any premium paid beyond the date of cancellation 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 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 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 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 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 G
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 (Unless Part B deductible has been met)
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 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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 (Unless Part B deductible has been met)
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 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 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.