

**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 <sup>1</sup>	K	L	M	N	C	F	F <sup>1</sup>
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%	✓	✓	✓	✓	✓
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 <sup>2</sup>						\$5,880 <sup>2</sup>	\$2,940 <sup>2</sup>					

<sup>1</sup> Plans F and G also have a high deductible option, which require first paying a plan deductible of \$2,370 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.

<sup>2</sup> 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.

<sup>3</sup> 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 Standard Premium Rates  
FOR USE IN INDIANA ZIP CODES  
463-464**

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	10,248	N/A	N/A	N/A	11,785	N/A	N/A	N/A
65	1,863	2,139	1,760	1,387	2,142	2,460	2,023	1,595
66	1,863	2,139	1,760	1,387	2,142	2,460	2,023	1,595
67	1,863	2,139	1,760	1,387	2,142	2,460	2,023	1,595
68	1,903	2,178	1,764	1,425	2,190	2,505	2,029	1,638
69	1,970	2,251	1,822	1,467	2,266	2,589	2,095	1,687
70	2,040	2,324	1,883	1,512	2,346	2,673	2,165	1,740
71	2,101	2,399	1,946	1,576	2,416	2,758	2,238	1,812
72	2,162	2,473	2,013	1,640	2,486	2,844	2,315	1,885
73	2,223	2,547	2,080	1,703	2,556	2,929	2,392	1,958
74	2,307	2,647	2,157	1,774	2,652	3,045	2,481	2,041
75	2,404	2,763	2,247	1,857	2,763	3,179	2,584	2,136
76	2,484	2,873	2,329	1,926	2,857	3,304	2,678	2,215
77	2,569	2,989	2,424	1,995	2,954	3,436	2,788	2,295
78	2,659	3,111	2,530	2,067	3,058	3,578	2,910	2,377
79	2,758	3,243	2,647	2,139	3,171	3,729	3,044	2,460
80	2,861	3,383	2,777	2,224	3,290	3,892	3,194	2,558
81	2,961	3,531	2,919	2,344	3,405	4,061	3,357	2,696
82	3,067	3,687	3,074	2,474	3,527	4,240	3,535	2,844
83	3,179	3,854	3,242	2,614	3,656	4,431	3,727	3,006
84	3,298	4,030	3,424	2,767	3,794	4,635	3,938	3,182
85	3,426	4,217	3,623	2,933	3,940	4,850	4,165	3,373
86	3,547	4,398	3,813	3,096	4,078	5,057	4,386	3,560
87	3,675	4,589	4,015	3,267	4,226	5,277	4,616	3,757
88	3,812	4,793	4,217	3,441	4,384	5,512	4,850	3,956
89	3,957	5,011	4,421	3,616	4,552	5,762	5,083	4,157
90	4,093	5,216	4,624	3,790	4,707	6,000	5,318	4,360
91	4,211	5,408	4,815	3,955	4,844	6,219	5,537	4,548
92	4,334	5,606	5,004	4,118	4,984	6,447	5,755	4,736
93	4,442	5,788	5,190	4,279	5,108	6,656	5,969	4,921
94	4,548	5,970	5,372	4,437	5,231	6,866	6,178	5,103
95	4,653	6,151	5,549	4,591	5,351	7,074	6,381	5,280
96	4,751	6,280	5,672	4,692	5,464	7,222	6,522	5,396
97	4,846	6,406	5,785	4,786	5,573	7,367	6,653	5,504
98	4,938	6,527	5,895	4,877	5,679	7,507	6,779	5,609
99	5,027	6,645	6,001	4,965	5,781	7,642	6,901	5,709

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 .93 is applied for household applicants.





**ManhattanLife Assurance Company of America  
Annual Preferred Premium Rates  
FOR USE IN INDIANA ZIP CODES ALL EXCEPT  
462-464**

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	6,819	N/A	N/A	N/A	7,842	N/A	N/A	N/A
65	1,240	1,423	1,170	923	1,426	1,637	1,346	1,061
66	1,240	1,423	1,170	923	1,426	1,637	1,346	1,061
67	1,240	1,423	1,170	923	1,426	1,637	1,346	1,061
68	1,266	1,449	1,174	948	1,456	1,667	1,350	1,090
69	1,311	1,498	1,212	977	1,507	1,722	1,394	1,123
70	1,357	1,546	1,253	1,007	1,561	1,778	1,441	1,157
71	1,397	1,596	1,294	1,049	1,608	1,836	1,489	1,206
72	1,438	1,646	1,339	1,091	1,654	1,892	1,540	1,255
73	1,479	1,695	1,384	1,133	1,701	1,949	1,592	1,303
74	1,535	1,762	1,435	1,181	1,765	2,026	1,651	1,358
75	1,599	1,839	1,495	1,236	1,839	2,115	1,720	1,421
76	1,653	1,911	1,550	1,281	1,901	2,198	1,782	1,474
77	1,709	1,989	1,613	1,328	1,966	2,287	1,855	1,527
78	1,770	2,070	1,683	1,375	2,035	2,380	1,936	1,581
79	1,835	2,158	1,762	1,424	2,110	2,482	2,026	1,637
80	1,904	2,251	1,848	1,480	2,189	2,589	2,125	1,702
81	1,970	2,350	1,942	1,559	2,266	2,702	2,233	1,793
82	2,041	2,453	2,045	1,646	2,347	2,821	2,352	1,893
83	2,116	2,564	2,157	1,740	2,432	2,949	2,481	2,000
84	2,195	2,681	2,278	1,841	2,524	3,084	2,620	2,117
85	2,279	2,806	2,410	1,952	2,622	3,227	2,772	2,244
86	2,360	2,926	2,538	2,060	2,714	3,365	2,918	2,369
87	2,446	3,054	2,671	2,174	2,812	3,511	3,072	2,500
88	2,536	3,189	2,805	2,289	2,917	3,668	3,227	2,633
89	2,634	3,333	2,941	2,406	3,028	3,834	3,383	2,767
90	2,724	3,472	3,076	2,522	3,132	3,992	3,538	2,900
91	2,803	3,598	3,204	2,632	3,223	4,139	3,685	3,026
92	2,884	3,730	3,330	2,740	3,317	4,290	3,829	3,151
93	2,956	3,852	3,453	2,847	3,399	4,429	3,971	3,274
94	3,026	3,972	3,575	2,952	3,480	4,568	4,110	3,395
95	3,096	4,093	3,692	3,054	3,560	4,707	4,246	3,513
96	3,161	4,179	3,773	3,122	3,635	4,806	4,340	3,590
97	3,224	4,263	3,849	3,185	3,708	4,902	4,426	3,663
98	3,286	4,344	3,922	3,245	3,779	4,995	4,511	3,732
99	3,345	4,422	3,993	3,304	3,846	5,085	4,592	3,799

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 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 and zip code 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, and the policy fee will be refunded.

### **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
<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 \$1484 All but \$371 a day  All but \$742 a day  \$0  \$0	\$0 \$371 a day  \$742 a day  100% of Medicare eligible expenses  \$0	\$1484 (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 \$185.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$185.50 a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b>  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 \$203 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 \$203 of Medicare Approved Amounts*	\$0	\$0	\$203 (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 \$203 of Medicare Approved Amounts*	\$0	\$0	\$203 (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 \$203 of Medicare Approved Amounts*	\$0	\$0	\$203 (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.

<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 \$1484 All but \$371 a day  All but \$742 a day  \$0  \$0	\$1484 (Part A deductible) \$371 a day  \$742 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 \$185.50 a day \$0	\$0 Up to \$185.50 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> 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 \$203 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 \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$203 (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 \$203 of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 \$0 80%	All costs \$203 (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 \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$203 (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.

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 \$1484 All but \$371 a day  All but \$742 a day  \$0  \$0	\$1484 (Part A deductible) \$371 a day  \$742 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 \$185.50 a day \$0	\$0 Up to \$185.50 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> 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 \$203 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 \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Generally 20%	\$203 (Part B deductible)  \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	0%
<b>BLOOD</b> First 3 pints Next \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$203 (Part B deductible) \$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 \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%  \$0 80%	\$0  \$0 20%	\$0  \$203 (Part B deductible) \$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<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 \$1484 All but \$371 a day  All but \$742 a day  \$0  \$0	\$1484 (Part A deductible) \$371 a day  \$742 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 \$185.50 a day \$0	\$0 Up to \$185.50 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> 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 \$203 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 \$203 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.	\$203 (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 \$203 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$203 (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 MEDICARE APPROVED SERVICES</b>			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$203 of Medicare Approved Amounts*	\$0	\$0	\$203 (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.