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 ISSUE AGE PREMIUMS
FOR USE IN GEORGIA ZIP CODES
300-303, 311, 313-314, 399

Issue Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	15,095	18,588	15,308	11,611	17,359	21,376	17,604	13,352
65	1,510	1,859	1,531	1,161	1,736	2,138	1,761	1,335
66	1,510	1,859	1,531	1,161	1,736	2,138	1,761	1,335
67	1,510	1,859	1,531	1,161	1,736	2,138	1,761	1,335
68	1,547	1,902	1,553	1,208	1,779	2,187	1,787	1,389
69	1,578	1,935	1,577	1,240	1,815	2,225	1,815	1,427
70	1,609	1,968	1,602	1,274	1,850	2,263	1,841	1,465
71	1,640	2,001	1,625	1,307	1,886	2,301	1,868	1,503
72	1,671	2,035	1,649	1,340	1,922	2,340	1,896	1,542
73	1,724	2,091	1,704	1,372	1,983	2,405	1,960	1,579
74	1,778	2,149	1,760	1,405	2,045	2,471	2,024	1,615
75	1,832	2,206	1,815	1,437	2,106	2,536	2,088	1,653
76	1,885	2,262	1,872	1,469	2,168	2,602	2,152	1,689
77	1,938	2,320	1,927	1,502	2,230	2,667	2,216	1,726
78	1,981	2,380	1,974	1,548	2,278	2,736	2,270	1,780
79	2,024	2,440	2,019	1,594	2,327	2,806	2,322	1,834
80	2,067	2,501	2,066	1,641	2,376	2,876	2,376	1,887
81	2,109	2,561	2,112	1,687	2,425	2,945	2,429	1,940
82	2,151	2,621	2,159	1,734	2,474	3,014	2,482	1,994
83	2,208	2,710	2,232	1,793	2,539	3,117	2,566	2,062
84	2,263	2,799	2,305	1,852	2,603	3,220	2,651	2,129
85	2,320	2,888	2,379	1,911	2,667	3,322	2,735	2,198
86	2,375	2,978	2,452	1,970	2,732	3,424	2,820	2,265
87	2,432	3,067	2,525	2,028	2,796	3,526	2,904	2,333
88	2,489	3,159	2,601	2,089	2,862	3,632	2,991	2,402
89	2,547	3,253	2,679	2,152	2,929	3,741	3,080	2,474
90	2,607	3,351	2,759	2,217	2,998	3,853	3,173	2,549
91	2,668	3,451	2,842	2,282	3,069	3,969	3,268	2,625
92	2,732	3,554	2,927	2,351	3,141	4,087	3,365	2,704
93	2,796	3,660	3,014	2,422	3,215	4,209	3,466	2,785
94	2,862	3,770	3,104	2,493	3,291	4,335	3,570	2,868
95	2,929	3,883	3,198	2,568	3,368	4,465	3,677	2,954
96	2,998	3,999	3,293	2,645	3,448	4,598	3,787	3,042
97	3,069	4,119	3,392	2,725	3,529	4,737	3,900	3,133
98	3,140	4,242	3,493	2,806	3,612	4,878	4,017	3,227
99	3,215	4,369	3,597	2,890	3,697	5,024	4,137	3,323

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.
The Early Enrollment Discount, described on page 6, has been applied to these rates.

ManhattanLife Assurance Company of America
ANNUAL STANDARD ISSUE AGE PREMIUMS
FOR USE IN GEORGIA ZIP CODES
300-303, 311, 313-314, 399

Issue	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	17,359	21,376	17,604	13,352	19,963	24,583	20,245	15,355
65	1,736	2,138	1,761	1,335	1,997	2,458	2,025	1,535
66	1,736	2,138	1,761	1,335	1,997	2,458	2,025	1,535
67	1,736	2,138	1,761	1,335	1,997	2,458	2,025	1,535
68	1,779	2,187	1,787	1,389	2,047	2,514	2,055	1,597
69	1,815	2,225	1,815	1,427	2,088	2,559	2,087	1,641
70	1,850	2,263	1,841	1,465	2,128	2,603	2,118	1,684
71	1,886	2,301	1,868	1,503	2,169	2,647	2,149	1,729
72	1,922	2,340	1,896	1,542	2,209	2,691	2,180	1,773
73	1,983	2,405	1,960	1,579	2,280	2,766	2,254	1,815
74	2,045	2,471	2,024	1,615	2,351	2,842	2,328	1,857
75	2,106	2,536	2,088	1,653	2,422	2,917	2,401	1,900
76	2,168	2,602	2,152	1,689	2,492	2,992	2,475	1,943
77	2,230	2,667	2,216	1,726	2,563	3,068	2,549	1,986
78	2,278	2,736	2,270	1,780	2,620	3,148	2,610	2,047
79	2,327	2,806	2,322	1,834	2,676	3,227	2,671	2,108
80	2,376	2,876	2,376	1,887	2,733	3,307	2,732	2,170
81	2,425	2,945	2,429	1,940	2,789	3,386	2,794	2,231
82	2,474	3,014	2,482	1,994	2,846	3,466	2,855	2,293
83	2,539	3,117	2,566	2,062	2,919	3,584	2,951	2,371
84	2,603	3,220	2,651	2,129	2,993	3,702	3,049	2,449
85	2,667	3,322	2,735	2,198	3,068	3,820	3,146	2,527
86	2,732	3,424	2,820	2,265	3,141	3,938	3,242	2,605
87	2,796	3,526	2,904	2,333	3,215	4,056	3,340	2,683
88	2,862	3,632	2,991	2,402	3,291	4,177	3,440	2,763
89	2,929	3,741	3,080	2,474	3,369	4,302	3,543	2,846
90	2,998	3,853	3,173	2,549	3,448	4,431	3,649	2,931
91	3,069	3,969	3,268	2,625	3,529	4,564	3,758	3,018
92	3,141	4,087	3,365	2,704	3,613	4,700	3,870	3,109
93	3,215	4,209	3,466	2,785	3,697	4,840	3,986	3,202
94	3,291	4,335	3,570	2,868	3,785	4,986	4,106	3,298
95	3,368	4,465	3,677	2,954	3,874	5,134	4,229	3,397
96	3,448	4,598	3,787	3,042	3,965	5,288	4,355	3,498
97	3,529	4,737	3,900	3,133	4,058	5,446	4,485	3,603
98	3,612	4,878	4,017	3,227	4,153	5,609	4,619	3,711
99	3,697	5,024	4,137	3,323	4,252	5,778	4,757	3,822

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.
The Early Enrollment Discount, described on page 6, has been applied to these rates.

ManhattanLife Assurance Company of America
ANNUAL PREFERRED ISSUE AGE PREMIUMS
FOR USE IN GEORGIA ZIP CODES ALL EXCEPT
300-303, 311, 313-314, 399

Issue	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	13,105	16,137	13,289	10,080	15,070	18,557	15,283	11,592
65	1,311	1,614	1,329	1,008	1,507	1,856	1,529	1,159
66	1,311	1,614	1,329	1,008	1,507	1,856	1,529	1,159
67	1,311	1,614	1,329	1,008	1,507	1,856	1,529	1,159
68	1,343	1,651	1,349	1,048	1,544	1,898	1,552	1,206
69	1,370	1,680	1,369	1,077	1,575	1,932	1,575	1,239
70	1,397	1,709	1,390	1,106	1,606	1,965	1,598	1,272
71	1,424	1,737	1,411	1,134	1,638	1,998	1,622	1,305
72	1,450	1,766	1,431	1,164	1,668	2,031	1,646	1,338
73	1,497	1,815	1,480	1,191	1,721	2,088	1,702	1,371
74	1,544	1,865	1,528	1,220	1,775	2,145	1,757	1,402
75	1,590	1,915	1,576	1,247	1,828	2,202	1,813	1,435
76	1,636	1,964	1,625	1,275	1,882	2,259	1,868	1,466
77	1,683	2,014	1,673	1,304	1,936	2,315	1,924	1,499
78	1,720	2,066	1,714	1,344	1,977	2,376	1,970	1,545
79	1,757	2,118	1,753	1,384	2,020	2,436	2,016	1,592
80	1,794	2,171	1,793	1,424	2,063	2,496	2,063	1,638
81	1,831	2,223	1,834	1,465	2,105	2,556	2,109	1,684
82	1,868	2,275	1,874	1,505	2,148	2,616	2,155	1,731
83	1,917	2,353	1,938	1,556	2,204	2,706	2,228	1,790
84	1,965	2,430	2,001	1,608	2,259	2,795	2,301	1,849
85	2,014	2,507	2,065	1,659	2,315	2,884	2,375	1,908
86	2,062	2,585	2,128	1,710	2,372	2,973	2,448	1,966
87	2,111	2,662	2,192	1,761	2,428	3,061	2,521	2,026
88	2,161	2,742	2,258	1,814	2,485	3,153	2,597	2,086
89	2,211	2,824	2,326	1,868	2,543	3,248	2,674	2,148
90	2,263	2,909	2,395	1,924	2,603	3,345	2,755	2,213
91	2,316	2,996	2,467	1,981	2,664	3,445	2,837	2,279
92	2,372	3,085	2,541	2,041	2,727	3,548	2,921	2,347
93	2,427	3,177	2,616	2,102	2,791	3,654	3,009	2,417
94	2,485	3,273	2,695	2,165	2,857	3,764	3,099	2,490
95	2,543	3,371	2,776	2,229	2,924	3,877	3,192	2,564
96	2,602	3,471	2,859	2,297	2,993	3,992	3,287	2,641
97	2,664	3,576	2,944	2,365	3,064	4,112	3,386	2,720
98	2,726	3,682	3,033	2,436	3,136	4,234	3,487	2,801
99	2,791	3,793	3,123	2,509	3,210	4,362	3,591	2,885

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.
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The Early Enrollment Discount, described on page 6, has been applied to these rates.

ManhattanLife Assurance Company of America
ANNUAL STANDARD ISSUE AGE PREMIUMS
FOR USE IN GEORGIA ZIP CODES ALL EXCEPT
300-303, 311, 313-314, 399

Issue	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	15,070	18,557	15,283	11,592	17,330	21,341	17,575	13,330
65	1,507	1,856	1,529	1,159	1,733	2,134	1,758	1,333
66	1,507	1,856	1,529	1,159	1,733	2,134	1,758	1,333
67	1,507	1,856	1,529	1,159	1,733	2,134	1,758	1,333
68	1,544	1,898	1,552	1,206	1,777	2,183	1,784	1,386
69	1,575	1,932	1,575	1,239	1,812	2,221	1,811	1,424
70	1,606	1,965	1,598	1,272	1,848	2,259	1,838	1,462
71	1,638	1,998	1,622	1,305	1,883	2,298	1,865	1,501
72	1,668	2,031	1,646	1,338	1,918	2,336	1,893	1,539
73	1,721	2,088	1,702	1,371	1,980	2,402	1,957	1,576
74	1,775	2,145	1,757	1,402	2,041	2,467	2,021	1,612
75	1,828	2,202	1,813	1,435	2,103	2,532	2,085	1,650
76	1,882	2,259	1,868	1,466	2,164	2,598	2,149	1,687
77	1,936	2,315	1,924	1,499	2,225	2,663	2,213	1,724
78	1,977	2,376	1,970	1,545	2,274	2,733	2,266	1,777
79	2,020	2,436	2,016	1,592	2,323	2,801	2,319	1,830
80	2,063	2,496	2,063	1,638	2,372	2,871	2,372	1,884
81	2,105	2,556	2,109	1,684	2,421	2,940	2,425	1,937
82	2,148	2,616	2,155	1,731	2,470	3,009	2,478	1,991
83	2,204	2,706	2,228	1,790	2,534	3,112	2,562	2,059
84	2,259	2,795	2,301	1,849	2,598	3,214	2,647	2,126
85	2,315	2,884	2,375	1,908	2,663	3,316	2,731	2,194
86	2,372	2,973	2,448	1,966	2,727	3,418	2,815	2,262
87	2,428	3,061	2,521	2,026	2,791	3,521	2,899	2,329
88	2,485	3,153	2,597	2,086	2,857	3,626	2,986	2,398
89	2,543	3,248	2,674	2,148	2,925	3,734	3,075	2,470
90	2,603	3,345	2,755	2,213	2,993	3,847	3,168	2,545
91	2,664	3,445	2,837	2,279	3,064	3,962	3,263	2,620
92	2,727	3,548	2,921	2,347	3,136	4,080	3,360	2,699
93	2,791	3,654	3,009	2,417	3,210	4,202	3,460	2,780
94	2,857	3,764	3,099	2,490	3,286	4,328	3,564	2,863
95	2,924	3,877	3,192	2,564	3,363	4,457	3,671	2,949
96	2,993	3,992	3,287	2,641	3,442	4,591	3,781	3,037
97	3,064	4,112	3,386	2,720	3,523	4,728	3,894	3,128
98	3,136	4,234	3,487	2,801	3,606	4,870	4,010	3,222
99	3,210	4,362	3,591	2,885	3,691	5,016	4,130	3,318

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.
The Early Enrollment Discount, described on page 6, has been applied to these rates.

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 Issue age, underwriting class, and state of residence. We will give You advance written notice as required by Your state prior to any premium change.

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

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum

PLAN N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1408	$1408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ 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.