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 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 $2,370 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.
[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 IOWA ZIP CODES
503, 515

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,360	1,560	1,283	983	1,562	1,795	1,476	1,130
66	1,360	1,560	1,283	983	1,562	1,795	1,476	1,130
67	1,360	1,560	1,283	983	1,562	1,795	1,476	1,130
68	1,388	1,589	1,299	1,015	1,596	1,827	1,495	1,167
69	1,437	1,642	1,336	1,045	1,653	1,887	1,536	1,202
70	1,488	1,694	1,373	1,078	1,711	1,949	1,580	1,239
71	1,532	1,750	1,420	1,123	1,763	2,012	1,633	1,290
72	1,576	1,804	1,468	1,168	1,814	2,074	1,689	1,343
73	1,622	1,858	1,517	1,213	1,865	2,137	1,745	1,395
74	1,683	1,931	1,574	1,259	1,935	2,220	1,811	1,448
75	1,753	2,016	1,639	1,311	2,016	2,318	1,885	1,508
76	1,812	2,095	1,699	1,360	2,084	2,410	1,954	1,563
77	1,874	2,180	1,769	1,409	2,155	2,507	2,035	1,621
78	1,940	2,269	1,846	1,460	2,230	2,609	2,123	1,678
79	2,011	2,365	1,931	1,510	2,313	2,720	2,221	1,737
80	2,088	2,467	2,026	1,570	2,400	2,838	2,330	1,805
81	2,159	2,575	2,129	1,654	2,484	2,961	2,449	1,903
82	2,237	2,689	2,243	1,746	2,573	3,092	2,578	2,008
83	2,319	2,811	2,365	1,845	2,666	3,232	2,719	2,122
84	2,406	2,939	2,498	1,954	2,766	3,380	2,873	2,247
85	2,498	3,076	2,643	2,070	2,874	3,537	3,039	2,381
86	2,587	3,208	2,782	2,186	2,975	3,688	3,200	2,513
87	2,681	3,347	2,928	2,307	3,083	3,848	3,367	2,653
88	2,780	3,495	3,076	2,429	3,198	4,020	3,538	2,793
89	2,887	3,654	3,225	2,553	3,319	4,202	3,709	2,936
90	2,986	3,806	3,373	2,676	3,433	4,375	3,879	3,079
91	3,072	3,944	3,514	2,792	3,533	4,536	4,039	3,211
92	3,161	4,089	3,651	2,907	3,635	4,703	4,199	3,343
93	3,241	4,222	3,787	3,021	3,726	4,855	4,354	3,473
94	3,317	4,354	3,919	3,132	3,815	5,007	4,507	3,602
95	3,393	4,486	4,049	3,241	3,903	5,160	4,656	3,727
96	3,465	4,581	4,137	3,312	3,985	5,268	4,758	3,809
97	3,534	4,673	4,221	3,379	4,065	5,373	4,853	3,885
98	3,602	4,761	4,300	3,443	4,142	5,475	4,946	3,959
99	3,666	4,848	4,378	3,504	4,216	5,574	5,034	4,030

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 IOWA ZIP CODES
503, 515

Attained	Female				Male			
Age	**Plan A**	**Plan F**	**Plan G**	**Plan N**	**Plan A**	**Plan F**	**Plan G**	**Plan N**
65	1,562	1,795	1,476	1,130	1,797	2,063	1,697	1,300
66	1,562	1,795	1,476	1,130	1,797	2,063	1,697	1,300
67	1,562	1,795	1,476	1,130	1,797	2,063	1,697	1,300
68	1,596	1,827	1,495	1,167	1,836	2,101	1,719	1,342
69	1,653	1,887	1,536	1,202	1,900	2,171	1,766	1,382
70	1,711	1,949	1,580	1,239	1,967	2,241	1,816	1,425
71	1,763	2,012	1,633	1,290	2,027	2,313	1,878	1,485
72	1,814	2,074	1,689	1,343	2,086	2,385	1,942	1,544
73	1,865	2,137	1,745	1,395	2,144	2,457	2,007	1,603
74	1,935	2,220	1,811	1,448	2,224	2,554	2,081	1,665
75	2,016	2,318	1,885	1,508	2,318	2,666	2,169	1,734
76	2,084	2,410	1,954	1,563	2,396	2,771	2,247	1,798
77	2,155	2,507	2,035	1,621	2,478	2,882	2,340	1,864
78	2,230	2,609	2,123	1,678	2,565	3,001	2,442	1,930
79	2,313	2,720	2,221	1,737	2,659	3,129	2,554	1,997
80	2,400	2,838	2,330	1,805	2,760	3,264	2,680	2,076
81	2,484	2,961	2,449	1,903	2,856	3,406	2,816	2,189
82	2,573	3,092	2,578	2,008	2,958	3,556	2,965	2,310
83	2,666	3,232	2,719	2,122	3,067	3,716	3,128	2,441
84	2,766	3,380	2,873	2,247	3,182	3,888	3,304	2,583
85	2,874	3,537	3,039	2,381	3,305	4,068	3,494	2,739
86	2,975	3,688	3,200	2,513	3,421	4,242	3,680	2,891
87	3,083	3,848	3,367	2,653	3,545	4,426	3,873	3,050
88	3,198	4,020	3,538	2,793	3,677	4,624	4,069	3,212
89	3,319	4,202	3,709	2,936	3,817	4,833	4,264	3,375
90	3,433	4,375	3,879	3,079	3,948	5,032	4,462	3,539
91	3,533	4,536	4,039	3,211	4,063	5,216	4,646	3,693
92	3,635	4,703	4,199	3,343	4,181	5,407	4,828	3,845
93	3,726	4,855	4,354	3,473	4,285	5,583	5,007	3,995
94	3,815	5,007	4,507	3,602	4,388	5,758	5,182	4,143
95	3,903	5,160	4,656	3,727	4,488	5,933	5,354	4,286
96	3,985	5,268	4,758	3,809	4,583	6,058	5,472	4,381
97	4,065	5,373	4,853	3,885	4,675	6,179	5,581	4,468
98	4,142	5,475	4,946	3,959	4,763	6,297	5,688	4,554
99	4,216	5,574	5,034	4,030	4,849	6,410	5,789	4,635

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 IOWA ZIP CODES
500-502, 504-514, 516, 520-528

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,180	1,354	1,114	853	1,356	1,558	1,281	981
66	1,180	1,354	1,114	853	1,356	1,558	1,281	981
67	1,180	1,354	1,114	853	1,356	1,558	1,281	981
68	1,205	1,379	1,128	881	1,386	1,586	1,298	1,013
69	1,247	1,425	1,160	907	1,435	1,638	1,334	1,044
70	1,292	1,471	1,192	936	1,485	1,692	1,371	1,076
71	1,330	1,519	1,232	975	1,530	1,747	1,418	1,120
72	1,368	1,566	1,274	1,014	1,574	1,800	1,466	1,166
73	1,408	1,613	1,317	1,053	1,619	1,855	1,515	1,211
74	1,461	1,676	1,367	1,093	1,680	1,928	1,572	1,257
75	1,522	1,750	1,423	1,138	1,750	2,012	1,636	1,309
76	1,573	1,819	1,475	1,181	1,809	2,092	1,696	1,357
77	1,627	1,893	1,536	1,223	1,871	2,176	1,766	1,407
78	1,684	1,969	1,603	1,267	1,936	2,265	1,843	1,457
79	1,746	2,053	1,676	1,311	2,008	2,361	1,928	1,508
80	1,812	2,142	1,759	1,363	2,083	2,464	2,022	1,567
81	1,875	2,236	1,849	1,436	2,157	2,571	2,126	1,652
82	1,942	2,334	1,947	1,516	2,233	2,684	2,238	1,744
83	2,013	2,440	2,053	1,602	2,315	2,806	2,361	1,842
84	2,089	2,552	2,169	1,696	2,402	2,934	2,494	1,951
85	2,169	2,670	2,294	1,797	2,495	3,071	2,639	2,067
86	2,246	2,785	2,415	1,898	2,583	3,202	2,778	2,182
87	2,327	2,906	2,542	2,003	2,677	3,341	2,923	2,303
88	2,413	3,034	2,670	2,109	2,776	3,490	3,072	2,425
89	2,507	3,172	2,800	2,216	2,881	3,648	3,220	2,549
90	2,592	3,304	2,929	2,323	2,981	3,798	3,368	2,673
91	2,667	3,424	3,050	2,424	3,067	3,938	3,507	2,788
92	2,744	3,549	3,169	2,524	3,156	4,083	3,645	2,902
93	2,813	3,666	3,287	2,623	3,235	4,215	3,780	3,015
94	2,880	3,780	3,403	2,719	3,312	4,347	3,913	3,127
95	2,946	3,895	3,515	2,814	3,388	4,479	4,042	3,236
96	3,008	3,977	3,591	2,876	3,459	4,573	4,131	3,307
97	3,068	4,057	3,664	2,933	3,529	4,664	4,213	3,373
98	3,127	4,133	3,733	2,989	3,596	4,753	4,294	3,437
99	3,183	4,208	3,801	3,042	3,660	4,839	4,370	3,499

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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ManhattanLife Assurance Company of America
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN IOWA ZIP CODES
500-502, 504-514, 516, 520-528

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,356	1,558	1,281	981	1,560	1,791	1,473	1,129
66	1,356	1,558	1,281	981	1,560	1,791	1,473	1,129
67	1,356	1,558	1,281	981	1,560	1,791	1,473	1,129
68	1,386	1,586	1,298	1,013	1,594	1,824	1,492	1,165
69	1,435	1,638	1,334	1,044	1,650	1,885	1,533	1,200
70	1,485	1,692	1,371	1,076	1,708	1,946	1,577	1,237
71	1,530	1,747	1,418	1,120	1,759	2,008	1,631	1,289
72	1,574	1,800	1,466	1,166	1,811	2,071	1,686	1,341
73	1,619	1,855	1,515	1,211	1,861	2,133	1,742	1,392
74	1,680	1,928	1,572	1,257	1,931	2,218	1,807	1,446
75	1,750	2,012	1,636	1,309	2,012	2,315	1,883	1,506
76	1,809	2,092	1,696	1,357	2,080	2,406	1,951	1,561
77	1,871	2,176	1,766	1,407	2,151	2,502	2,031	1,618
78	1,936	2,265	1,843	1,457	2,227	2,605	2,120	1,676
79	2,008	2,361	1,928	1,508	2,308	2,716	2,218	1,734
80	2,083	2,464	2,022	1,567	2,396	2,834	2,327	1,802
81	2,157	2,571	2,126	1,652	2,480	2,957	2,445	1,900
82	2,233	2,684	2,238	1,744	2,568	3,087	2,574	2,005
83	2,315	2,806	2,361	1,842	2,662	3,226	2,715	2,119
84	2,402	2,934	2,494	1,951	2,763	3,375	2,868	2,243
85	2,495	3,071	2,639	2,067	2,869	3,531	3,034	2,378
86	2,583	3,202	2,778	2,182	2,970	3,682	3,195	2,510
87	2,677	3,341	2,923	2,303	3,078	3,843	3,362	2,648
88	2,776	3,490	3,072	2,425	3,192	4,014	3,532	2,789
89	2,881	3,648	3,220	2,549	3,314	4,196	3,702	2,930
90	2,981	3,798	3,368	2,673	3,428	4,369	3,873	3,072
91	3,067	3,938	3,507	2,788	3,527	4,528	4,033	3,206
92	3,156	4,083	3,645	2,902	3,629	4,694	4,191	3,338
93	3,235	4,215	3,780	3,015	3,720	4,847	4,347	3,468
94	3,312	4,347	3,913	3,127	3,809	4,999	4,499	3,597
95	3,388	4,479	4,042	3,236	3,896	5,151	4,648	3,721
96	3,459	4,573	4,131	3,307	3,978	5,259	4,750	3,803
97	3,529	4,664	4,213	3,373	4,058	5,364	4,845	3,879
98	3,596	4,753	4,294	3,437	4,135	5,467	4,938	3,953
99	3,660	4,839	4,370	3,499	4,210	5,565	5,026	4,023

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 $1484	$0	$1484 (Part A deductible)
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	$0	Up to $185.50 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 $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
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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1484	$1484 (Part A deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $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
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 $203 of Medicare Approved Amounts*	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$203 (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 $203 of Medicare Approved Amounts*	$0	$203 (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 $1484	$1484 (Part A deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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.

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
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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $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
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 $1484	$1484 (Part A deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $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
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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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	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
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.