ManhattanLife Assurance Company of America
Outline of Medicare Supplement Coverage-Cover Page
Benefit Plans A, F, G, AND N

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020.

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A." Some plans may not be available in your state. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F. ManhattanLife Assurance Company of America offers four of the twelve plans available, Plans A, F, G, and N.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants									Medicare first eligible before 2020 only		
	A	B	D	G	G[1]	K	L	M	N	C	F	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Medicare Part B coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓ Copays apply[3]	✓	✓	
Blood (first three pints)	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Part A hospice care coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Skilled nursing facility coinsurance			✓	✓		50%	75%	✓	✓	✓	✓	
Medicare Part A deductible		✓	✓	✓		50%	75%	50%	✓	✓	✓	
Medicare Part B deductible										✓	✓	
Medicare Part B excess charges				✓							✓	
Foreign travel emergency (up to plan limits)			✓	✓				✓	✓	✓	✓	
Out-of-pocket limit in 2022[2]						$6,620[2]	$3,310[2]					

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,490 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.
[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.
[3] Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

ManhattanLife Assurance Company of America
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN NEW MEXICO ZIP CODES
871

Attained	Female				Male			
Age	**Plan A**	**Plan F**	**Plan G**	**Plan N**	**Plan A**	**Plan F**	**Plan G**	**Plan N**
65	1,282	1,540	1,210	955	1,474	1,771	1,392	1,097
66	1,282	1,540	1,210	955	1,474	1,771	1,392	1,097
67	1,282	1,540	1,210	955	1,474	1,771	1,392	1,097
68	1,309	1,568	1,214	980	1,506	1,804	1,396	1,127
69	1,356	1,621	1,253	1,010	1,559	1,864	1,441	1,161
70	1,403	1,673	1,296	1,041	1,614	1,925	1,490	1,197
71	1,445	1,727	1,339	1,085	1,663	1,986	1,540	1,247
72	1,487	1,781	1,385	1,128	1,711	2,048	1,593	1,298
73	1,530	1,834	1,431	1,171	1,759	2,109	1,646	1,348
74	1,587	1,906	1,484	1,221	1,825	2,192	1,707	1,404
75	1,653	1,990	1,546	1,278	1,902	2,289	1,778	1,470
76	1,709	2,068	1,603	1,325	1,966	2,379	1,843	1,524
77	1,767	2,152	1,668	1,373	2,033	2,474	1,918	1,579
78	1,830	2,240	1,741	1,422	2,104	2,576	2,002	1,635
79	1,897	2,335	1,822	1,472	2,182	2,685	2,095	1,693
80	1,969	2,436	1,911	1,531	2,264	2,802	2,198	1,760
81	2,037	2,543	2,008	1,613	2,343	2,924	2,310	1,855
82	2,110	2,655	2,115	1,702	2,427	3,053	2,432	1,957
83	2,188	2,775	2,230	1,799	2,515	3,190	2,565	2,068
84	2,270	2,901	2,356	1,904	2,610	3,337	2,709	2,189
85	2,357	3,037	2,492	2,018	2,711	3,492	2,867	2,321
86	2,441	3,166	2,624	2,130	2,806	3,641	3,018	2,450
87	2,529	3,304	2,762	2,248	2,908	3,799	3,177	2,585
88	2,623	3,451	2,901	2,367	3,017	3,969	3,337	2,723
89	2,724	3,607	3,041	2,488	3,131	4,149	3,498	2,861
90	2,816	3,756	3,181	2,608	3,239	4,320	3,659	2,999
91	2,898	3,894	3,313	2,722	3,332	4,478	3,810	3,129
92	2,982	4,037	3,443	2,834	3,430	4,642	3,959	3,259
93	3,057	4,168	3,571	2,944	3,515	4,793	4,107	3,386
94	3,129	4,299	3,696	3,053	3,599	4,943	4,251	3,511
95	3,201	4,429	3,818	3,159	3,682	5,093	4,391	3,633
96	3,269	4,522	3,902	3,229	3,759	5,201	4,488	3,713
97	3,334	4,613	3,980	3,293	3,835	5,304	4,577	3,787
98	3,398	4,700	4,056	3,355	3,908	5,405	4,665	3,859
99	3,459	4,785	4,129	3,416	3,978	5,503	4,748	3,928

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.

ManhattanLife Assurance Company of America
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN NEW MEXICO ZIP CODES
871

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,474	1,771	1,392	1,097	1,695	2,037	1,601	1,262
66	1,474	1,771	1,392	1,097	1,695	2,037	1,601	1,262
67	1,474	1,771	1,392	1,097	1,695	2,037	1,601	1,262
68	1,506	1,804	1,396	1,127	1,733	2,074	1,605	1,296
69	1,559	1,864	1,441	1,161	1,793	2,143	1,658	1,335
70	1,614	1,925	1,490	1,197	1,856	2,213	1,714	1,377
71	1,663	1,986	1,540	1,247	1,912	2,284	1,771	1,434
72	1,711	2,048	1,593	1,298	1,967	2,355	1,832	1,491
73	1,759	2,109	1,646	1,348	2,023	2,425	1,893	1,550
74	1,825	2,192	1,707	1,404	2,098	2,522	1,963	1,615
75	1,902	2,289	1,778	1,470	2,187	2,632	2,045	1,690
76	1,966	2,379	1,843	1,524	2,260	2,735	2,119	1,753
77	2,033	2,474	1,918	1,579	2,338	2,846	2,206	1,816
78	2,104	2,576	2,002	1,635	2,420	2,962	2,302	1,881
79	2,182	2,685	2,095	1,693	2,509	3,089	2,409	1,946
80	2,264	2,802	2,198	1,760	2,604	3,222	2,527	2,024
81	2,343	2,924	2,310	1,855	2,695	3,362	2,656	2,133
82	2,427	3,053	2,432	1,957	2,791	3,512	2,797	2,250
83	2,515	3,190	2,565	2,068	2,893	3,669	2,949	2,379
84	2,610	3,337	2,709	2,189	3,002	3,837	3,116	2,518
85	2,711	3,492	2,867	2,321	3,118	4,016	3,296	2,669
86	2,806	3,641	3,018	2,450	3,227	4,187	3,471	2,817
87	2,908	3,799	3,177	2,585	3,344	4,370	3,653	2,973
88	3,017	3,969	3,337	2,723	3,469	4,564	3,837	3,130
89	3,131	4,149	3,498	2,861	3,602	4,771	4,022	3,290
90	3,239	4,320	3,659	2,999	3,725	4,968	4,208	3,450
91	3,332	4,478	3,810	3,129	3,833	5,150	4,382	3,599
92	3,430	4,642	3,959	3,259	3,944	5,338	4,554	3,747
93	3,515	4,793	4,107	3,386	4,042	5,512	4,723	3,894
94	3,599	4,943	4,251	3,511	4,140	5,685	4,889	4,038
95	3,682	5,093	4,391	3,633	4,234	5,858	5,050	4,178
96	3,759	5,201	4,488	3,713	4,323	5,981	5,161	4,270
97	3,835	5,304	4,577	3,787	4,410	6,100	5,264	4,355
98	3,908	5,405	4,665	3,859	4,494	6,216	5,364	4,438
99	3,978	5,503	4,748	3,928	4,575	6,328	5,461	4,517

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.

ManhattanLife Assurance Company of America
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN NEW MEXICO ZIP CODES
870, 872-884

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,169	1,404	1,104	871	1,345	1,615	1,270	1,001
66	1,169	1,404	1,104	871	1,345	1,615	1,270	1,001
67	1,169	1,404	1,104	871	1,345	1,615	1,270	1,001
68	1,194	1,430	1,107	894	1,374	1,645	1,273	1,028
69	1,237	1,478	1,143	921	1,422	1,700	1,315	1,059
70	1,280	1,526	1,182	950	1,472	1,755	1,359	1,091
71	1,318	1,575	1,221	989	1,516	1,811	1,404	1,137
72	1,356	1,624	1,263	1,029	1,560	1,868	1,453	1,184
73	1,395	1,672	1,306	1,068	1,604	1,924	1,501	1,229
74	1,448	1,739	1,354	1,114	1,665	1,999	1,557	1,281
75	1,508	1,815	1,410	1,165	1,735	2,087	1,622	1,340
76	1,559	1,887	1,462	1,208	1,793	2,170	1,681	1,390
77	1,612	1,963	1,521	1,252	1,854	2,257	1,750	1,440
78	1,669	2,043	1,588	1,297	1,919	2,350	1,826	1,492
79	1,731	2,130	1,662	1,343	1,990	2,449	1,911	1,544
80	1,796	2,222	1,743	1,396	2,065	2,556	2,004	1,605
81	1,858	2,319	1,832	1,471	2,137	2,667	2,107	1,692
82	1,925	2,422	1,929	1,552	2,214	2,785	2,219	1,785
83	1,995	2,531	2,034	1,641	2,294	2,910	2,340	1,887
84	2,070	2,646	2,149	1,736	2,380	3,044	2,471	1,997
85	2,150	2,770	2,273	1,841	2,473	3,185	2,615	2,117
86	2,226	2,888	2,394	1,943	2,560	3,321	2,752	2,234
87	2,307	3,014	2,519	2,050	2,653	3,465	2,898	2,358
88	2,392	3,147	2,646	2,159	2,751	3,620	3,044	2,483
89	2,484	3,290	2,774	2,269	2,856	3,784	3,191	2,610
90	2,569	3,426	2,902	2,379	2,954	3,940	3,337	2,736
91	2,644	3,552	3,022	2,483	3,039	4,084	3,475	2,854
92	2,720	3,682	3,141	2,585	3,128	4,234	3,611	2,972
93	2,788	3,801	3,257	2,685	3,206	4,372	3,746	3,088
94	2,854	3,921	3,371	2,785	3,283	4,509	3,877	3,202
95	2,920	4,040	3,483	2,881	3,358	4,646	4,005	3,313
96	2,981	4,124	3,559	2,945	3,429	4,743	4,094	3,386
97	3,041	4,207	3,630	3,004	3,498	4,838	4,175	3,454
98	3,099	4,287	3,699	3,060	3,564	4,930	4,255	3,520
99	3,155	4,364	3,766	3,116	3,628	5,019	4,331	3,583

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.

ManhattanLife Assurance Company of America
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN NEW MEXICO ZIP CODES
870, 872-884

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,345	1,615	1,270	1,001	1,546	1,858	1,460	1,151
66	1,345	1,615	1,270	1,001	1,546	1,858	1,460	1,151
67	1,345	1,615	1,270	1,001	1,546	1,858	1,460	1,151
68	1,374	1,645	1,273	1,028	1,580	1,892	1,464	1,182
69	1,422	1,700	1,315	1,059	1,635	1,955	1,512	1,218
70	1,472	1,755	1,359	1,091	1,693	2,019	1,563	1,256
71	1,516	1,811	1,404	1,137	1,744	2,083	1,615	1,308
72	1,560	1,868	1,453	1,184	1,794	2,148	1,671	1,360
73	1,604	1,924	1,501	1,229	1,845	2,212	1,726	1,413
74	1,665	1,999	1,557	1,281	1,914	2,300	1,790	1,473
75	1,735	2,087	1,622	1,340	1,994	2,400	1,865	1,541
76	1,793	2,170	1,681	1,390	2,062	2,495	1,933	1,599
77	1,854	2,257	1,750	1,440	2,132	2,595	2,012	1,657
78	1,919	2,350	1,826	1,492	2,207	2,702	2,100	1,716
79	1,990	2,449	1,911	1,544	2,288	2,817	2,197	1,775
80	2,065	2,556	2,004	1,605	2,375	2,939	2,305	1,846
81	2,137	2,667	2,107	1,692	2,458	3,067	2,423	1,946
82	2,214	2,785	2,219	1,785	2,546	3,203	2,551	2,053
83	2,294	2,910	2,340	1,887	2,639	3,347	2,690	2,170
84	2,380	3,044	2,471	1,997	2,738	3,500	2,842	2,297
85	2,473	3,185	2,615	2,117	2,844	3,663	3,006	2,434
86	2,560	3,321	2,752	2,234	2,943	3,819	3,166	2,570
87	2,653	3,465	2,898	2,358	3,050	3,986	3,332	2,712
88	2,751	3,620	3,044	2,483	3,164	4,162	3,500	2,855
89	2,856	3,784	3,191	2,610	3,285	4,352	3,669	3,000
90	2,954	3,940	3,337	2,736	3,397	4,531	3,838	3,147
91	3,039	4,084	3,475	2,854	3,496	4,697	3,996	3,283
92	3,128	4,234	3,611	2,972	3,597	4,869	4,153	3,418
93	3,206	4,372	3,746	3,088	3,687	5,027	4,308	3,552
94	3,283	4,509	3,877	3,202	3,776	5,185	4,459	3,683
95	3,358	4,646	4,005	3,313	3,862	5,343	4,606	3,811
96	3,429	4,743	4,094	3,386	3,943	5,455	4,707	3,894
97	3,498	4,838	4,175	3,454	4,022	5,563	4,802	3,972
98	3,564	4,930	4,255	3,520	4,099	5,670	4,893	4,048
99	3,628	5,019	4,331	3,583	4,172	5,772	4,981	4,120

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 of residence.

Premiums are based on your attained age and will change on Your Policy Anniversary Date.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and ManhattanLife Assurance Company of America.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to our Medicare Supplement Administrative Office at P. O. Box 925568, Houston, Texas 77292-5568. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither ManhattanLife Assurance Company of America nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

LIMITATIONS AND EXCLUSIONS

This Policy does not pay expenses related to any coverage that is limited or excluded by Medicare related to services not "reasonable and Medically Necessary" under the Medicare Program Standards for diagnosis or treatment of Injury or Sickness.

REFUND OF PREMIUMS

The Policy does contain a Pro-Rata Refund provision which provides for the partial refund of premium upon death.

The Policy does contain a Cancellation By Insured provision which provides for a refund of premium upon surrender of the Policy.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Please refer to your policy for details.

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1556	$0	$1556 (Part A deductible)
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $194.50 a day	$0	Up to $194.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

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

*Once you have been billed $233 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $233 of Medicare Approved Amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $233 of Medicare Approved Amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $233 of Medicare Approved Amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1556	$1556 (Part A deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

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

*Once you have been billed $233 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $233 of Medicare Approved Amounts*	$0	$233 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $233 of Medicare Approved amounts*	$0	$233 (Part B deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $233 of Medicare Approved Amounts*	$0	$233 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER SERVICES – NOT COVERED BY MEDICARE

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

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1556	$1556 (Part A deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

*Once you have been billed $233 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $233 of Medicare Approved Amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	0%
BLOOD			
First 3 pints	$0	All costs	$0
Next $233 of Medicare Approved Amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $233 of Medicare Approved Amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1556	$1556 (Part A deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

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

*Once you have been billed $233 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $233 of Medicare Approved Amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $233 of Medicare Approved Amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $233 of Medicare Approved Amounts*	$0	$0	$233 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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