

THE MANHATTAN LIFE INSURANCE COMPANY
Outline of Medicare Supplement Coverage-Cover Page
Benefit Plans A, C, F, G, AND N

These charts show 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. The Manhattan Life Insurance Company offers five of the eleven plans available.

Plans E, H, I, and J are no longer available for sale.

Basic Benefits:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or co-payments.

Blood: First three pints of blood each year.

Hospice: Part A coinsurance

A	B	C	D	F	F*	G	K	L	M	N
Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance*		Basic Benefits, including 100% Part B coinsurance	Hospitalization and preventative care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventative care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit \$4620; paid at 100% after limit reached	Out-of-pocket limit \$2310; paid at 100% after limit reached		

*Plans F also have an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare Deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible

**THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN OREGON ZIP CODES
970-972**

Attained Age	Female					Male				
	Plan A	Plan C	Plan F	Plan G	Plan N	Plan A	Plan C	Plan F	Plan G	Plan N
0-64	1,395	1,848	1,867	1,584	1,284	1,604	2,123	2,145	1,820	1,475
65	1,395	1,848	1,867	1,584	1,284	1,604	2,123	2,145	1,820	1,475
66	1,395	1,848	1,867	1,584	1,284	1,604	2,123	2,145	1,820	1,475
67	1,395	1,848	1,867	1,584	1,284	1,604	2,123	2,145	1,820	1,475
68	1,454	1,920	1,941	1,654	1,340	1,672	2,208	2,232	1,901	1,540
69	1,512	1,995	2,017	1,726	1,396	1,739	2,293	2,319	1,984	1,604
70	1,569	2,066	2,087	1,793	1,449	1,804	2,374	2,400	2,061	1,665
71	1,616	2,133	2,156	1,857	1,502	1,857	2,452	2,478	2,136	1,725
72	1,663	2,200	2,224	1,922	1,554	1,911	2,530	2,556	2,210	1,786
73	1,711	2,268	2,292	1,987	1,607	1,966	2,608	2,635	2,283	1,848
74	1,758	2,336	2,361	2,051	1,660	2,020	2,685	2,714	2,358	1,909
75	1,806	2,405	2,431	2,119	1,715	2,076	2,765	2,795	2,435	1,971
76	1,849	2,479	2,505	2,186	1,773	2,124	2,849	2,879	2,512	2,038
77	1,891	2,553	2,579	2,254	1,832	2,174	2,934	2,966	2,592	2,105
78	1,936	2,631	2,658	2,327	1,893	2,225	3,023	3,056	2,674	2,176
79	1,982	2,708	2,738	2,401	1,956	2,278	3,114	3,147	2,759	2,248
80	2,028	2,789	2,820	2,475	2,020	2,332	3,206	3,240	2,844	2,322
81	2,071	2,874	2,904	2,554	2,089	2,381	3,303	3,338	2,935	2,401
82	2,114	2,959	2,991	2,632	2,159	2,429	3,402	3,438	3,026	2,482
83	2,159	3,050	3,082	2,716	2,233	2,482	3,506	3,543	3,122	2,567
84	2,206	3,142	3,175	2,803	2,309	2,535	3,612	3,649	3,221	2,654
85	2,253	3,236	3,269	2,889	2,386	2,590	3,719	3,758	3,321	2,743
86	2,303	3,334	3,368	2,978	2,465	2,647	3,831	3,870	3,424	2,833
87	2,354	3,433	3,469	3,069	2,545	2,706	3,946	3,987	3,528	2,926
88	2,406	3,536	3,571	3,164	2,628	2,765	4,064	4,106	3,637	3,022
89	2,455	3,634	3,671	3,254	2,708	2,822	4,177	4,219	3,739	3,113
90	2,501	3,730	3,767	3,343	2,786	2,876	4,288	4,330	3,842	3,203
91	2,542	3,820	3,858	3,425	2,861	2,922	4,391	4,434	3,936	3,289
92	2,577	3,904	3,943	3,501	2,931	2,962	4,487	4,532	4,024	3,369
93	2,609	3,981	4,020	3,573	2,995	2,999	4,576	4,622	4,107	3,443
94	2,639	4,060	4,099	3,645	3,062	3,034	4,667	4,713	4,190	3,520
95	2,671	4,140	4,180	3,718	3,129	3,070	4,760	4,805	4,275	3,598
96	2,725	4,223	4,265	3,793	3,191	3,132	4,855	4,901	4,360	3,669
97	2,780	4,307	4,349	3,868	3,256	3,195	4,950	4,998	4,446	3,742
98	2,835	4,394	4,437	3,946	3,321	3,259	5,050	5,099	4,535	3,817
99	2,892	4,482	4,525	4,025	3,387	3,324	5,151	5,201	4,627	3,893

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 .88 is applied for household discount applicants

**THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN OREGON ZIP CODES
970-972**

Attained Age	Female					Male				
	Plan A	Plan C	Plan F	Plan G	Plan N	Plan A	Plan C	Plan F	Plan G	Plan N
0-64	1,604	2,123	2,145	1,820	1,475	1,843	2,441	2,466	2,093	1,696
65	1,604	2,123	2,145	1,820	1,475	1,843	2,441	2,466	2,093	1,696
66	1,604	2,123	2,145	1,820	1,475	1,843	2,441	2,466	2,093	1,696
67	1,604	2,123	2,145	1,820	1,475	1,843	2,441	2,466	2,093	1,696
68	1,672	2,208	2,232	1,901	1,540	1,922	2,537	2,564	2,185	1,770
69	1,739	2,293	2,319	1,984	1,604	1,999	2,636	2,665	2,280	1,843
70	1,804	2,374	2,400	2,061	1,665	2,073	2,728	2,759	2,368	1,913
71	1,857	2,452	2,478	2,136	1,725	2,136	2,818	2,849	2,454	1,983
72	1,911	2,530	2,556	2,210	1,786	2,197	2,908	2,938	2,539	2,053
73	1,966	2,608	2,635	2,283	1,848	2,259	2,996	3,029	2,625	2,124
74	2,020	2,685	2,714	2,358	1,909	2,322	3,086	3,119	2,710	2,194
75	2,076	2,765	2,795	2,435	1,971	2,385	3,179	3,213	2,799	2,266
76	2,124	2,849	2,879	2,512	2,038	2,442	3,275	3,310	2,888	2,343
77	2,174	2,934	2,966	2,592	2,105	2,498	3,372	3,408	2,979	2,420
78	2,225	3,023	3,056	2,674	2,176	2,557	3,475	3,511	3,074	2,500
79	2,278	3,114	3,147	2,759	2,248	2,619	3,579	3,617	3,171	2,584
80	2,332	3,206	3,240	2,844	2,322	2,681	3,685	3,725	3,270	2,669
81	2,381	3,303	3,338	2,935	2,401	2,736	3,796	3,836	3,373	2,760
82	2,429	3,402	3,438	3,026	2,482	2,793	3,910	3,951	3,478	2,853
83	2,482	3,506	3,543	3,122	2,567	2,853	4,029	4,072	3,588	2,952
84	2,535	3,612	3,649	3,221	2,654	2,914	4,152	4,194	3,701	3,050
85	2,590	3,719	3,758	3,321	2,743	2,976	4,276	4,320	3,817	3,153
86	2,647	3,831	3,870	3,424	2,833	3,042	4,404	4,450	3,935	3,257
87	2,706	3,946	3,987	3,528	2,926	3,110	4,536	4,582	4,055	3,363
88	2,765	4,064	4,106	3,637	3,022	3,179	4,671	4,719	4,179	3,473
89	2,822	4,177	4,219	3,739	3,113	3,243	4,800	4,849	4,299	3,578
90	2,876	4,288	4,330	3,842	3,203	3,305	4,928	4,978	4,416	3,682
91	2,922	4,391	4,434	3,936	3,289	3,358	5,047	5,097	4,524	3,780
92	2,962	4,487	4,532	4,024	3,369	3,406	5,158	5,209	4,626	3,872
93	2,999	4,576	4,622	4,107	3,443	3,447	5,260	5,312	4,720	3,958
94	3,034	4,667	4,713	4,190	3,520	3,487	5,364	5,417	4,816	4,046
95	3,070	4,760	4,805	4,275	3,598	3,529	5,469	5,522	4,912	4,134
96	3,132	4,855	4,901	4,360	3,669	3,601	5,579	5,634	5,011	4,216
97	3,195	4,950	4,998	4,446	3,742	3,672	5,691	5,746	5,111	4,302
98	3,259	5,050	5,099	4,535	3,817	3,746	5,805	5,861	5,214	4,387
99	3,324	5,151	5,201	4,627	3,893	3,820	5,921	5,978	5,317	4,475

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 0.88 is applied for household discount applicants

**THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN OREGON ZIP CODES ALL EXCEPT
970-972**

Attained Age	Female					Male				
	Plan A	Plan C	Plan F	Plan G	Plan N	Plan A	Plan C	Plan F	Plan G	Plan N
0-64	1,307	1,731	1,749	1,484	1,203	1,502	1,989	2,010	1,705	1,382
65	1,307	1,731	1,749	1,484	1,203	1,502	1,989	2,010	1,705	1,382
66	1,307	1,731	1,749	1,484	1,203	1,502	1,989	2,010	1,705	1,382
67	1,307	1,731	1,749	1,484	1,203	1,502	1,989	2,010	1,705	1,382
68	1,363	1,799	1,818	1,549	1,255	1,566	2,068	2,091	1,781	1,443
69	1,417	1,869	1,889	1,617	1,307	1,629	2,148	2,172	1,858	1,502
70	1,470	1,936	1,955	1,679	1,357	1,690	2,224	2,248	1,930	1,560
71	1,514	1,998	2,019	1,740	1,407	1,740	2,297	2,321	2,001	1,616
72	1,558	2,061	2,083	1,800	1,456	1,791	2,370	2,395	2,070	1,673
73	1,603	2,124	2,148	1,862	1,506	1,841	2,443	2,469	2,139	1,731
74	1,647	2,189	2,212	1,922	1,555	1,892	2,515	2,543	2,209	1,788
75	1,692	2,253	2,278	1,985	1,606	1,945	2,591	2,618	2,281	1,847
76	1,732	2,322	2,347	2,048	1,661	1,990	2,669	2,698	2,353	1,909
77	1,771	2,391	2,416	2,112	1,716	2,036	2,748	2,779	2,428	1,972
78	1,814	2,464	2,490	2,180	1,774	2,084	2,832	2,863	2,505	2,038
79	1,857	2,537	2,565	2,249	1,833	2,134	2,917	2,949	2,585	2,106
80	1,900	2,613	2,642	2,318	1,892	2,185	3,004	3,036	2,665	2,175
81	1,940	2,692	2,721	2,392	1,957	2,230	3,095	3,127	2,749	2,249
82	1,980	2,772	2,802	2,466	2,023	2,276	3,187	3,221	2,835	2,326
83	2,023	2,857	2,887	2,545	2,092	2,326	3,284	3,319	2,925	2,405
84	2,067	2,943	2,974	2,626	2,164	2,375	3,384	3,418	3,017	2,487
85	2,111	3,031	3,062	2,706	2,236	2,426	3,484	3,521	3,111	2,569
86	2,157	3,123	3,155	2,790	2,310	2,480	3,589	3,626	3,208	2,654
87	2,205	3,216	3,250	2,876	2,384	2,535	3,697	3,735	3,305	2,741
88	2,254	3,313	3,346	2,964	2,462	2,591	3,807	3,847	3,407	2,831
89	2,300	3,404	3,439	3,048	2,537	2,643	3,913	3,952	3,503	2,917
90	2,343	3,494	3,529	3,132	2,610	2,694	4,017	4,057	3,599	3,001
91	2,382	3,579	3,614	3,208	2,681	2,738	4,114	4,154	3,687	3,081
92	2,415	3,657	3,694	3,280	2,746	2,775	4,203	4,245	3,770	3,156
93	2,444	3,730	3,766	3,347	2,806	2,810	4,287	4,330	3,847	3,225
94	2,472	3,804	3,840	3,415	2,868	2,843	4,373	4,415	3,925	3,297
95	2,503	3,879	3,916	3,483	2,932	2,876	4,459	4,502	4,005	3,370
96	2,553	3,956	3,995	3,554	2,990	2,934	4,548	4,592	4,084	3,437
97	2,604	4,035	4,074	3,624	3,050	2,993	4,638	4,682	4,165	3,506
98	2,656	4,116	4,156	3,697	3,111	3,053	4,731	4,777	4,249	3,576
99	2,709	4,199	4,239	3,771	3,173	3,114	4,826	4,873	4,334	3,647

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 .88 is applied for household discount applicants

**THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN OREGON ZIP CODES ALL EXCEPT
970-972**

Attained Age	Female					Male				
	Plan A	Plan C	Plan F	Plan G	Plan N	Plan A	Plan C	Plan F	Plan G	Plan N
0-64	1,502	1,989	2,010	1,705	1,382	1,727	2,286	2,310	1,961	1,589
65	1,502	1,989	2,010	1,705	1,382	1,727	2,286	2,310	1,961	1,589
66	1,502	1,989	2,010	1,705	1,382	1,727	2,286	2,310	1,961	1,589
67	1,502	1,989	2,010	1,705	1,382	1,727	2,286	2,310	1,961	1,589
68	1,566	2,068	2,091	1,781	1,443	1,800	2,377	2,402	2,047	1,658
69	1,629	2,148	2,172	1,858	1,502	1,873	2,470	2,496	2,136	1,727
70	1,690	2,224	2,248	1,930	1,560	1,942	2,556	2,585	2,219	1,792
71	1,740	2,297	2,321	2,001	1,616	2,001	2,640	2,669	2,299	1,857
72	1,791	2,370	2,395	2,070	1,673	2,059	2,724	2,753	2,379	1,923
73	1,841	2,443	2,469	2,139	1,731	2,116	2,807	2,837	2,459	1,990
74	1,892	2,515	2,543	2,209	1,788	2,175	2,891	2,922	2,539	2,055
75	1,945	2,591	2,618	2,281	1,847	2,235	2,978	3,010	2,622	2,123
76	1,990	2,669	2,698	2,353	1,909	2,287	3,068	3,101	2,706	2,195
77	2,036	2,748	2,779	2,428	1,972	2,340	3,159	3,192	2,791	2,267
78	2,084	2,832	2,863	2,505	2,038	2,396	3,256	3,289	2,880	2,342
79	2,134	2,917	2,949	2,585	2,106	2,454	3,353	3,388	2,971	2,421
80	2,185	3,004	3,036	2,665	2,175	2,512	3,452	3,490	3,063	2,500
81	2,230	3,095	3,127	2,749	2,249	2,563	3,556	3,594	3,160	2,585
82	2,276	3,187	3,221	2,835	2,326	2,617	3,663	3,702	3,258	2,673
83	2,326	3,284	3,319	2,925	2,405	2,673	3,774	3,815	3,362	2,765
84	2,375	3,384	3,418	3,017	2,487	2,730	3,889	3,929	3,467	2,858
85	2,426	3,484	3,521	3,111	2,569	2,788	4,006	4,047	3,576	2,954
86	2,480	3,589	3,626	3,208	2,654	2,850	4,126	4,169	3,686	3,051
87	2,535	3,697	3,735	3,305	2,741	2,914	4,250	4,292	3,799	3,151
88	2,591	3,807	3,847	3,407	2,831	2,978	4,376	4,421	3,915	3,254
89	2,643	3,913	3,952	3,503	2,917	3,038	4,497	4,543	4,027	3,352
90	2,694	4,017	4,057	3,599	3,001	3,096	4,616	4,664	4,137	3,450
91	2,738	4,114	4,154	3,687	3,081	3,146	4,729	4,775	4,238	3,541
92	2,775	4,203	4,245	3,770	3,156	3,191	4,832	4,880	4,333	3,628
93	2,810	4,287	4,330	3,847	3,225	3,229	4,928	4,977	4,422	3,708
94	2,843	4,373	4,415	3,925	3,297	3,267	5,025	5,075	4,511	3,791
95	2,876	4,459	4,502	4,005	3,370	3,306	5,124	5,174	4,602	3,873
96	2,934	4,548	4,592	4,084	3,437	3,373	5,227	5,278	4,695	3,950
97	2,993	4,638	4,682	4,165	3,506	3,440	5,332	5,383	4,788	4,030
98	3,053	4,731	4,777	4,249	3,576	3,509	5,439	5,490	4,884	4,110
99	3,114	4,826	4,873	4,334	3,647	3,579	5,547	5,601	4,981	4,193

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 .88 is applied for household discount applicants

PREMIUM INFORMATION

The Manhattan Life Insurance Company 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.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.

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 The Manhattan Life Insurance Company.

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 The Manhattan Life Insurance Company 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 serviced 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 61 st thru 90 th day 91 st 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 \$1316 All but \$329 a day All but \$658 a day \$0 \$0	\$0 \$329 a day \$658 a day 100% of Medicare eligible expenses \$0	\$1316 (Part A deductible) \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$164.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$164.50 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 \$183 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 \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (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 \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (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 \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN C

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 61 st thru 90 th day 91 st 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 \$1316 All but \$329 a day All but \$658 a day \$0 \$0	\$1316 (Part A deductible) \$329 a day \$658 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$164.50 a day \$0	\$0 Up to \$164.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 C

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

*Once you have been billed \$183 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 \$183 of Medicare Approved Amounts*	\$0	\$183 (Part B deductible)	\$0
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 \$183 of Medicare Approved Amounts*	\$0	\$183 (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

HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment First \$183 of Medicare Approved Amounts*	\$0	\$183 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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 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 61 st thru 90 th day 91 st 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 \$1316 All but \$329 a day All but \$658 a day \$0 \$0	\$1316 (Part A deductible) \$329 a day \$658 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$164.50 a day \$0	\$0 Up to \$164.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 \$183 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 \$183 of Medicare Approved Amounts*	\$0	\$183 (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 \$183 of Medicare Approved amounts*	\$0	\$183 (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 \$183 of Medicare Approved Amounts*	\$0	\$183 (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 61 st thru 90 th day 91 st 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 \$1316 All but \$329 a day All but \$658 a day \$0 \$0	\$1316 (Part A deductible) \$329 a day \$658 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$164.50 a day \$0	\$0 Up to \$164.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 \$183 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 \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$183 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	0%
BLOOD First 3 pints Next \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$183 (Part B deductible) \$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 — Durable medical equipment First \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$183 (Part B deductible) \$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>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</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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61 st thru 90 th day 91 st 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 \$1316 All but \$329 a day All but \$658 a day \$0 \$0	\$1316 (Part A deductible) \$329 a day \$658 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$164.50 a day \$0	\$0 Up to \$164.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 \$183 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 \$183 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.	\$183 (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.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$183 (Part B deductible) \$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 \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (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.