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 $2240 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2240. 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 NEW MEXICO ZIP CODES
871

Attained Age	Female					Male				
	Plan A	Plan C	Plan F	Plan G	Plan N	Plan A	Plan C	Plan F	Plan G	Plan N
65	1,353	1,779	1,772	1,407	1,132	1,503	1,977	1,968	1,616	1,255
66	1,353	1,779	1,772	1,407	1,132	1,503	1,977	1,968	1,616	1,255
67	1,353	1,779	1,772	1,407	1,132	1,503	1,977	1,968	1,616	1,255
68	1,414	1,862	1,850	1,467	1,191	1,570	2,065	2,056	1,687	1,321
69	1,472	1,936	1,927	1,532	1,250	1,633	2,148	2,136	1,761	1,384
70	1,529	2,012	2,002	1,592	1,308	1,698	2,234	2,222	1,829	1,449
71	1,590	2,093	2,084	1,649	1,367	1,768	2,323	2,311	1,894	1,517
72	1,653	2,178	2,166	1,706	1,432	1,836	2,417	2,405	1,961	1,587
73	1,703	2,243	2,232	1,764	1,479	1,891	2,489	2,476	2,027	1,643
74	1,755	2,310	2,300	1,821	1,530	1,948	2,564	2,550	2,093	1,702
75	1,806	2,379	2,367	1,881	1,584	2,006	2,641	2,626	2,160	1,756
76	1,862	2,450	2,437	1,939	1,637	2,067	2,720	2,706	2,228	1,818
77	1,917	2,524	2,511	1,998	1,692	2,128	2,800	2,786	2,296	1,881
78	1,977	2,600	2,588	2,060	1,750	2,193	2,885	2,871	2,366	1,943
79	2,035	2,678	2,664	2,122	1,810	2,259	2,971	2,956	2,440	2,009
80	2,094	2,757	2,747	2,187	1,869	2,325	3,061	3,045	2,516	2,077
81	2,148	2,826	2,813	2,255	1,923	2,384	3,138	3,123	2,591	2,135
82	2,192	2,883	2,869	2,324	1,965	2,432	3,200	3,186	2,672	2,182
83	2,234	2,940	2,927	2,395	2,009	2,481	3,265	3,248	2,752	2,229
84	2,279	2,999	2,985	2,469	2,054	2,531	3,330	3,314	2,837	2,280
85	2,315	3,044	3,030	2,541	2,087	2,569	3,378	3,362	2,923	2,317
86	2,348	3,090	3,075	2,616	2,122	2,606	3,430	3,413	3,007	2,356
87	2,373	3,121	3,108	2,693	2,146	2,631	3,464	3,449	3,096	2,381
88	2,394	3,152	3,138	2,769	2,169	2,657	3,500	3,483	3,183	2,409
89	2,419	3,186	3,169	2,848	2,194	2,686	3,533	3,516	3,275	2,435
90	2,444	3,215	3,200	2,924	2,218	2,713	3,569	3,553	3,361	2,461
91	2,468	3,248	3,232	2,987	2,243	2,742	3,606	3,588	3,433	2,489
92	2,493	3,281	3,265	3,049	2,265	2,768	3,641	3,626	3,505	2,516
93	2,518	3,314	3,297	3,109	2,292	2,795	3,677	3,660	3,574	2,544
94	2,543	3,346	3,330	3,169	2,316	2,824	3,714	3,695	3,643	2,572
95	2,569	3,378	3,362	3,228	2,341	2,852	3,751	3,734	3,713	2,600
96	2,594	3,413	3,396	3,288	2,366	2,880	3,789	3,771	3,779	2,630
97	2,620	3,449	3,430	3,347	2,394	2,908	3,827	3,808	3,850	2,655
98	2,647	3,483	3,464	3,409	2,420	2,938	3,865	3,847	3,920	2,685
99	2,673	3,516	3,500	3,471	2,444	2,968	3,903	3,885	3,990	2,714

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.

THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN NEW MEXICO ZIP CODES
871

Attained Age	Female					Male				
	Plan A	Plan C	Plan F	Plan G	Plan N	Plan A	Plan C	Plan F	Plan G	Plan N
65	1,504	1,979	1,971	1,616	1,257	1,671	2,199	2,186	1,859	1,395
66	1,504	1,979	1,971	1,616	1,257	1,671	2,199	2,186	1,859	1,395
67	1,504	1,979	1,971	1,616	1,257	1,671	2,199	2,186	1,859	1,395
68	1,572	2,071	2,059	1,687	1,323	1,746	2,296	2,284	1,940	1,471
69	1,637	2,153	2,141	1,761	1,388	1,817	2,390	2,378	2,024	1,539
70	1,701	2,237	2,229	1,829	1,452	1,887	2,485	2,470	2,103	1,612
71	1,771	2,326	2,316	1,894	1,521	1,964	2,582	2,572	2,179	1,687
72	1,840	2,420	2,410	1,961	1,590	2,042	2,686	2,675	2,254	1,766
73	1,897	2,494	2,482	2,027	1,646	2,103	2,768	2,754	2,330	1,828
74	1,952	2,569	2,556	2,093	1,704	2,167	2,852	2,837	2,405	1,890
75	2,009	2,645	2,633	2,160	1,762	2,231	2,937	2,924	2,484	1,956
76	2,071	2,724	2,712	2,228	1,822	2,298	3,023	3,011	2,561	2,022
77	2,134	2,806	2,794	2,296	1,884	2,367	3,114	3,099	2,638	2,090
78	2,197	2,891	2,876	2,366	1,946	2,438	3,206	3,192	2,719	2,160
79	2,262	2,979	2,964	2,440	2,011	2,512	3,303	3,288	2,805	2,232
80	2,330	3,065	3,051	2,516	2,079	2,588	3,405	3,387	2,892	2,310
81	2,390	3,144	3,127	2,591	2,138	2,651	3,488	3,472	2,979	2,373
82	2,437	3,205	3,190	2,672	2,185	2,704	3,559	3,540	3,070	2,428
83	2,484	3,270	3,255	2,752	2,234	2,758	3,631	3,613	3,165	2,479
84	2,536	3,334	3,319	2,837	2,284	2,813	3,703	3,685	3,261	2,535
85	2,574	3,384	3,371	2,923	2,321	2,856	3,758	3,739	3,358	2,576
86	2,612	3,436	3,420	3,007	2,361	2,900	3,815	3,795	3,457	2,618
87	2,638	3,471	3,455	3,096	2,385	2,927	3,852	3,834	3,556	2,649
88	2,666	3,505	3,488	3,183	2,411	2,956	3,891	3,871	3,659	2,678
89	2,692	3,539	3,522	3,275	2,438	2,987	3,929	3,910	3,760	2,708
90	2,719	3,576	3,559	3,361	2,467	3,017	3,970	3,948	3,863	2,737
91	2,747	3,612	3,594	3,433	2,493	3,046	4,008	3,991	3,946	2,767
92	2,772	3,646	3,631	3,505	2,519	3,076	4,050	4,031	4,029	2,797
93	2,800	3,685	3,665	3,574	2,549	3,107	4,089	4,070	4,108	2,827
94	2,827	3,720	3,704	3,643	2,575	3,140	4,130	4,110	4,186	2,860
95	2,856	3,758	3,741	3,713	2,605	3,171	4,171	4,151	4,266	2,891
96	2,886	3,795	3,777	3,779	2,633	3,202	4,213	4,192	4,345	2,923
97	2,913	3,834	3,816	3,850	2,661	3,233	4,255	4,235	4,423	2,954
98	2,942	3,871	3,852	3,920	2,689	3,267	4,298	4,277	4,503	2,985
99	2,971	3,910	3,892	3,990	2,719	3,300	4,340	4,321	4,584	3,019

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.

THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN NEW MEXICO ZIP CODES ALL EXCEPT
871

Attained Age	Female					Male				
	Plan A	Plan C	Plan F	Plan G	Plan N	Plan A	Plan C	Plan F	Plan G	Plan N
65	1,239	1,630	1,623	1,288	1,037	1,377	1,810	1,803	1,480	1,150
66	1,239	1,630	1,623	1,288	1,037	1,377	1,810	1,803	1,480	1,150
67	1,239	1,630	1,623	1,288	1,037	1,377	1,810	1,803	1,480	1,150
68	1,295	1,706	1,695	1,344	1,091	1,438	1,891	1,884	1,546	1,210
69	1,348	1,773	1,765	1,403	1,145	1,495	1,967	1,957	1,613	1,268
70	1,401	1,843	1,833	1,458	1,198	1,555	2,046	2,035	1,675	1,328
71	1,456	1,917	1,909	1,511	1,252	1,620	2,128	2,117	1,735	1,390
72	1,514	1,995	1,984	1,563	1,311	1,682	2,214	2,203	1,796	1,454
73	1,560	2,055	2,045	1,615	1,355	1,732	2,280	2,268	1,856	1,505
74	1,608	2,116	2,107	1,668	1,402	1,784	2,349	2,336	1,917	1,559
75	1,655	2,179	2,168	1,723	1,451	1,838	2,419	2,406	1,978	1,609
76	1,706	2,244	2,232	1,776	1,500	1,893	2,492	2,479	2,040	1,666
77	1,756	2,312	2,300	1,830	1,550	1,949	2,565	2,552	2,103	1,723
78	1,810	2,382	2,371	1,887	1,603	2,009	2,642	2,630	2,167	1,780
79	1,864	2,453	2,441	1,943	1,658	2,069	2,722	2,708	2,235	1,840
80	1,918	2,526	2,516	2,003	1,712	2,130	2,803	2,789	2,304	1,902
81	1,967	2,589	2,577	2,066	1,761	2,183	2,874	2,860	2,373	1,955
82	2,008	2,641	2,628	2,129	1,800	2,228	2,931	2,918	2,447	1,999
83	2,046	2,693	2,681	2,194	1,840	2,273	2,991	2,975	2,521	2,042
84	2,087	2,747	2,734	2,262	1,881	2,318	3,050	3,036	2,599	2,088
85	2,120	2,788	2,775	2,327	1,912	2,353	3,095	3,079	2,677	2,122
86	2,151	2,831	2,817	2,396	1,943	2,387	3,141	3,126	2,754	2,158
87	2,173	2,859	2,847	2,467	1,965	2,410	3,173	3,159	2,836	2,181
88	2,193	2,887	2,874	2,536	1,987	2,434	3,206	3,190	2,916	2,206
89	2,216	2,918	2,903	2,608	2,010	2,460	3,236	3,221	3,000	2,230
90	2,239	2,945	2,931	2,678	2,032	2,485	3,269	3,255	3,078	2,254
91	2,261	2,975	2,960	2,736	2,055	2,511	3,303	3,286	3,145	2,280
92	2,284	3,005	2,991	2,793	2,074	2,535	3,335	3,321	3,210	2,304
93	2,306	3,036	3,020	2,848	2,099	2,560	3,368	3,353	3,273	2,330
94	2,329	3,065	3,050	2,903	2,121	2,587	3,402	3,384	3,336	2,355
95	2,353	3,095	3,079	2,957	2,144	2,613	3,436	3,420	3,401	2,382
96	2,376	3,126	3,111	3,012	2,167	2,638	3,471	3,454	3,462	2,409
97	2,400	3,159	3,141	3,066	2,193	2,664	3,505	3,488	3,526	2,432
98	2,424	3,190	3,173	3,123	2,217	2,691	3,540	3,524	3,590	2,459
99	2,448	3,221	3,206	3,180	2,239	2,718	3,575	3,559	3,655	2,486

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.

THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN NEW MEXICO ZIP CODES ALL EXCEPT
871

Attained Age	Female					Male				
	Plan A	Plan C	Plan F	Plan G	Plan N	Plan A	Plan C	Plan F	Plan G	Plan N
65	1,378	1,813	1,805	1,480	1,151	1,530	2,014	2,002	1,703	1,277
66	1,378	1,813	1,805	1,480	1,151	1,530	2,014	2,002	1,703	1,277
67	1,378	1,813	1,805	1,480	1,151	1,530	2,014	2,002	1,703	1,277
68	1,440	1,897	1,886	1,546	1,212	1,599	2,103	2,092	1,777	1,347
69	1,500	1,972	1,961	1,613	1,271	1,664	2,189	2,178	1,854	1,409
70	1,558	2,049	2,042	1,675	1,330	1,729	2,276	2,263	1,926	1,477
71	1,622	2,131	2,121	1,735	1,393	1,799	2,365	2,355	1,996	1,546
72	1,685	2,217	2,207	1,796	1,456	1,870	2,460	2,450	2,064	1,618
73	1,737	2,285	2,274	1,856	1,507	1,926	2,535	2,522	2,134	1,674
74	1,788	2,353	2,341	1,917	1,561	1,985	2,613	2,599	2,203	1,731
75	1,840	2,423	2,412	1,978	1,614	2,044	2,690	2,678	2,275	1,792
76	1,897	2,495	2,484	2,040	1,669	2,105	2,769	2,758	2,346	1,852
77	1,954	2,570	2,559	2,103	1,725	2,168	2,853	2,838	2,417	1,914
78	2,012	2,648	2,635	2,167	1,782	2,233	2,936	2,923	2,491	1,978
79	2,072	2,728	2,715	2,235	1,842	2,301	3,026	3,012	2,569	2,045
80	2,134	2,808	2,795	2,304	1,904	2,371	3,118	3,102	2,649	2,116
81	2,189	2,880	2,865	2,373	1,959	2,429	3,195	3,181	2,728	2,173
82	2,232	2,935	2,922	2,447	2,001	2,476	3,260	3,243	2,812	2,224
83	2,275	2,995	2,981	2,521	2,046	2,527	3,326	3,309	2,899	2,270
84	2,323	3,054	3,040	2,599	2,092	2,577	3,392	3,376	2,987	2,322
85	2,358	3,100	3,088	2,677	2,126	2,616	3,442	3,425	3,076	2,360
86	2,393	3,147	3,133	2,754	2,163	2,656	3,495	3,476	3,166	2,398
87	2,417	3,180	3,164	2,836	2,184	2,681	3,528	3,512	3,257	2,426
88	2,442	3,210	3,195	2,916	2,208	2,708	3,564	3,546	3,352	2,453
89	2,466	3,242	3,226	3,000	2,233	2,736	3,599	3,582	3,444	2,481
90	2,491	3,275	3,260	3,078	2,260	2,763	3,636	3,617	3,538	2,507
91	2,516	3,308	3,292	3,145	2,284	2,790	3,671	3,656	3,614	2,534
92	2,539	3,340	3,326	3,210	2,308	2,818	3,709	3,692	3,691	2,562
93	2,565	3,376	3,357	3,273	2,335	2,846	3,745	3,728	3,763	2,590
94	2,590	3,407	3,393	3,336	2,359	2,877	3,783	3,765	3,835	2,619
95	2,616	3,442	3,427	3,401	2,386	2,905	3,820	3,802	3,908	2,648
96	2,643	3,476	3,460	3,462	2,412	2,933	3,859	3,840	3,980	2,677
97	2,668	3,512	3,496	3,526	2,437	2,962	3,898	3,879	4,052	2,705
98	2,694	3,546	3,528	3,590	2,463	2,992	3,937	3,917	4,125	2,734
99	2,722	3,582	3,565	3,655	2,491	3,023	3,975	3,958	4,199	2,765

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.

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	All but $1340	$0	$1340 (Part A deductible)
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	$0	Up to $167.50 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			
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	All but $1340	$1340 (Part A deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	Up to $167.50 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 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	All but $1340	$1340 (Part A deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	Up to $167.50 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 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	All but $1340	$1340 (Part A deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	Up to $167.50 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			
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 G
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	100%	0%
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

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 $1340	$1340 (Part A deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	Up to $167.50 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			
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*	$0	$0	$183 (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 $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

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 $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
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.