THE MANHATTAN LIFE INSURANCE COMPANY
Outline of Medicare Supplement Coverage-Cover Page
Benefit Plans A, C, F, 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 four 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 coinsuran ce	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 $2000 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2000. 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 ILLINOIS ZIP CODES
600-608

Attained	Female				Male			
Age	Plan A	Plan C	Plan F	Plan N	Plan A	Plan C	Plan F	Plan N
0-64	3,435	N/A	N/A	N/A	3,813	N/A	N/A	N/A
65	1,279	1,716	1,707	1,162	1,420	1,905	1,895	1,290
66	1,279	1,716	1,707	1,162	1,420	1,905	1,895	1,290
67	1,279	1,716	1,707	1,162	1,420	1,905	1,895	1,290
68	1,337	1,792	1,784	1,224	1,484	1,991	1,980	1,358
69	1,390	1,864	1,856	1,279	1,543	2,070	2,060	1,421
70	1,446	1,939	1,929	1,338	1,605	2,152	2,142	1,486
71	1,503	2,017	2,007	1,399	1,670	2,238	2,228	1,553
72	1,564	2,098	2,087	1,462	1,736	2,328	2,316	1,624
73	1,611	2,161	2,150	1,512	1,788	2,398	2,386	1,678
74	1,659	2,225	2,215	1,564	1,842	2,470	2,458	1,735
75	1,709	2,292	2,281	1,615	1,897	2,544	2,532	1,794
76	1,761	2,361	2,349	1,670	1,954	2,621	2,608	1,853
77	1,814	2,432	2,420	1,725	2,013	2,699	2,686	1,915
78	1,868	2,504	2,492	1,783	2,073	2,780	2,767	1,979
79	1,923	2,579	2,568	1,842	2,135	2,864	2,850	2,044
80	1,981	2,657	2,644	1,902	2,200	2,949	2,935	2,112
81	2,031	2,723	2,710	1,954	2,254	3,023	3,008	2,170
82	2,071	2,778	2,765	1,998	2,300	3,083	3,068	2,217
83	2,113	2,833	2,820	2,041	2,346	3,145	3,129	2,266
84	2,155	2,890	2,876	2,086	2,392	3,208	3,193	2,315
85	2,188	2,933	2,919	2,119	2,428	3,257	3,240	2,353
86	2,221	2,977	2,963	2,155	2,465	3,305	3,289	2,392
87	2,242	3,008	2,992	2,178	2,489	3,338	3,322	2,418
88	2,264	3,037	3,023	2,202	2,515	3,371	3,355	2,444
89	2,288	3,068	3,053	2,225	2,539	3,405	3,389	2,470
90	2,310	3,099	3,083	2,249	2,564	3,440	3,422	2,497
91	2,334	3,129	3,114	2,274	2,590	3,474	3,456	2,524
92	2,356	3,161	3,146	2,299	2,616	3,508	3,492	2,551
93	2,380	3,192	3,177	2,323	2,642	3,544	3,526	2,578
94	2,404	3,224	3,208	2,348	2,669	3,579	3,561	2,607
95	2,428	3,257	3,240	2,374	2,695	3,614	3,597	2,635
96	2,452	3,289	3,273	2,399	2,722	3,651	3,633	2,663
97	2,477	3,322	3,306	2,425	2,749	3,688	3,670	2,692
98	2,502	3,355	3,339	2,451	2,777	3,724	3,706	2,721
99	2,526	3,389	3,372	2,478	2,805	3,762	3,743	2,751

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 ILLINOIS ZIP CODES
600-608

Attained	Female				Male			
Age	Plan A	Plan C	Plan F	Plan N	Plan A	Plan C	Plan F	Plan N
0-64	3,820	N/A	N/A	N/A	4,240	N/A	N/A	N/A
65	1,423	1,908	1,899	1,292	1,579	2,118	2,107	1,435
66	1,423	1,908	1,899	1,292	1,579	2,118	2,107	1,435
67	1,423	1,908	1,899	1,292	1,579	2,118	2,107	1,435
68	1,487	1,994	1,984	1,361	1,651	2,213	2,202	1,509
69	1,546	2,073	2,064	1,423	1,716	2,302	2,290	1,579
70	1,608	2,157	2,146	1,488	1,785	2,394	2,382	1,652
71	1,672	2,243	2,231	1,555	1,856	2,490	2,477	1,728
72	1,739	2,333	2,321	1,626	1,930	2,589	2,576	1,805
73	1,791	2,402	2,391	1,682	1,988	2,667	2,654	1,867
74	1,846	2,474	2,463	1,738	2,048	2,747	2,733	1,929
75	1,901	2,549	2,536	1,796	2,110	2,830	2,815	1,994
76	1,958	2,626	2,613	1,856	2,172	2,913	2,899	2,060
77	2,017	2,703	2,690	1,919	2,238	3,002	2,987	2,130
78	2,077	2,785	2,772	1,982	2,306	3,092	3,076	2,201
79	2,139	2,869	2,854	2,047	2,374	3,184	3,168	2,273
80	2,203	2,955	2,941	2,116	2,446	3,279	3,264	2,348
81	2,259	3,029	3,014	2,174	2,506	3,362	3,345	2,413
82	2,303	3,089	3,074	2,221	2,557	3,429	3,413	2,465
83	2,349	3,151	3,135	2,270	2,608	3,498	3,481	2,519
84	2,397	3,214	3,198	2,320	2,660	3,567	3,551	2,575
85	2,432	3,262	3,246	2,358	2,700	3,621	3,604	2,616
86	2,469	3,311	3,295	2,395	2,740	3,676	3,657	2,660
87	2,493	3,344	3,328	2,421	2,768	3,712	3,693	2,688
88	2,518	3,377	3,361	2,449	2,795	3,749	3,731	2,718
89	2,544	3,411	3,395	2,474	2,824	3,787	3,768	2,747
90	2,569	3,446	3,429	2,502	2,852	3,824	3,806	2,777
91	2,595	3,480	3,463	2,529	2,880	3,862	3,844	2,806
92	2,621	3,515	3,498	2,556	2,909	3,901	3,882	2,837
93	2,647	3,549	3,533	2,583	2,938	3,940	3,921	2,867
94	2,674	3,585	3,568	2,611	2,968	3,980	3,960	2,898
95	2,700	3,621	3,604	2,640	2,997	4,019	4,000	2,930
96	2,727	3,658	3,639	2,668	3,027	4,059	4,040	2,962
97	2,754	3,695	3,676	2,696	3,057	4,101	4,080	2,994
98	2,782	3,731	3,712	2,726	3,088	4,142	4,122	3,026
99	2,810	3,768	3,750	2,755	3,119	4,183	4,162	3,059

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 ILLINOIS ZIP CODES ALL EXCEPT
600-608

Attained	Female				Male			
Age	Plan A	Plan C	Plan F	Plan N	Plan A	Plan C	Plan F	Plan N
0-64	2,911	N/A	N/A	N/A	3,231	N/A	N/A	N/A
65	1,084	1,454	1,447	985	1,203	1,614	1,606	1,093
66	1,084	1,454	1,447	985	1,203	1,614	1,606	1,093
67	1,084	1,454	1,447	985	1,203	1,614	1,606	1,093
68	1,133	1,519	1,512	1,037	1,258	1,687	1,678	1,151
69	1,178	1,580	1,573	1,084	1,308	1,754	1,746	1,204
70	1,225	1,643	1,635	1,134	1,360	1,824	1,815	1,259
71	1,274	1,709	1,701	1,186	1,415	1,897	1,888	1,316
72	1,325	1,778	1,769	1,239	1,471	1,973	1,963	1,376
73	1,365	1,831	1,822	1,281	1,515	2,032	2,022	1,422
74	1,406	1,886	1,877	1,325	1,561	2,093	2,083	1,470
75	1,448	1,942	1,933	1,369	1,608	2,156	2,146	1,520
76	1,492	2,001	1,991	1,415	1,656	2,221	2,210	1,570
77	1,537	2,061	2,051	1,462	1,706	2,287	2,276	1,623
78	1,583	2,122	2,112	1,511	1,757	2,356	2,345	1,677
79	1,630	2,186	2,176	1,561	1,809	2,427	2,415	1,732
80	1,679	2,252	2,241	1,612	1,864	2,499	2,487	1,790
81	1,721	2,308	2,297	1,656	1,910	2,562	2,549	1,839
82	1,755	2,354	2,343	1,693	1,949	2,613	2,600	1,879
83	1,791	2,401	2,390	1,730	1,988	2,665	2,652	1,920
84	1,826	2,449	2,437	1,768	2,027	2,719	2,706	1,962
85	1,854	2,486	2,474	1,796	2,058	2,760	2,746	1,994
86	1,882	2,523	2,511	1,826	2,089	2,801	2,787	2,027
87	1,900	2,549	2,536	1,846	2,109	2,829	2,815	2,049
88	1,919	2,574	2,562	1,866	2,131	2,857	2,843	2,071
89	1,939	2,600	2,587	1,886	2,152	2,886	2,872	2,093
90	1,958	2,626	2,613	1,906	2,173	2,915	2,900	2,116
91	1,978	2,652	2,639	1,927	2,195	2,944	2,929	2,139
92	1,997	2,679	2,666	1,948	2,217	2,973	2,959	2,162
93	2,017	2,705	2,692	1,969	2,239	3,003	2,988	2,185
94	2,037	2,732	2,719	1,990	2,262	3,033	3,018	2,209
95	2,058	2,760	2,746	2,012	2,284	3,063	3,048	2,233
96	2,078	2,787	2,774	2,033	2,307	3,094	3,079	2,257
97	2,099	2,815	2,802	2,055	2,330	3,125	3,110	2,281
98	2,120	2,843	2,830	2,077	2,353	3,156	3,141	2,306
99	2,141	2,872	2,858	2,100	2,377	3,188	3,172	2,331

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 ILLINOIS ZIP CODES ALL EXCEPT
600-608

Attained	Female				Male			
Age	Plan A	Plan C	Plan F	Plan N	Plan A	Plan C	Plan F	Plan N
0-64	3,237	N/A	N/A	N/A	3,593	N/A	N/A	N/A
65	1,206	1,617	1,609	1,095	1,338	1,795	1,786	1,216
66	1,206	1,617	1,609	1,095	1,338	1,795	1,786	1,216
67	1,206	1,617	1,609	1,095	1,338	1,795	1,786	1,216
68	1,260	1,690	1,681	1,153	1,399	1,875	1,866	1,279
69	1,310	1,757	1,749	1,206	1,454	1,951	1,941	1,338
70	1,363	1,828	1,819	1,261	1,513	2,029	2,019	1,400
71	1,417	1,901	1,891	1,318	1,573	2,110	2,099	1,464
72	1,474	1,977	1,967	1,378	1,636	2,194	2,183	1,530
73	1,518	2,036	2,026	1,425	1,685	2,260	2,249	1,582
74	1,564	2,097	2,087	1,473	1,736	2,328	2,316	1,635
75	1,611	2,160	2,149	1,522	1,788	2,398	2,386	1,690
76	1,659	2,225	2,214	1,573	1,841	2,469	2,457	1,746
77	1,709	2,291	2,280	1,626	1,897	2,544	2,531	1,805
78	1,760	2,360	2,349	1,680	1,954	2,620	2,607	1,865
79	1,813	2,431	2,419	1,735	2,012	2,698	2,685	1,926
80	1,867	2,504	2,492	1,793	2,073	2,779	2,766	1,990
81	1,914	2,567	2,554	1,842	2,124	2,849	2,835	2,045
82	1,952	2,618	2,605	1,882	2,167	2,906	2,892	2,089
83	1,991	2,670	2,657	1,924	2,210	2,964	2,950	2,135
84	2,031	2,724	2,710	1,966	2,254	3,023	3,009	2,182
85	2,061	2,764	2,751	1,998	2,288	3,069	3,054	2,217
86	2,092	2,806	2,792	2,030	2,322	3,115	3,099	2,254
87	2,113	2,834	2,820	2,052	2,346	3,146	3,130	2,278
88	2,134	2,862	2,848	2,075	2,369	3,177	3,162	2,303
89	2,156	2,891	2,877	2,097	2,393	3,209	3,193	2,328
90	2,177	2,920	2,906	2,120	2,417	3,241	3,225	2,353
91	2,199	2,949	2,935	2,143	2,441	3,273	3,258	2,378
92	2,221	2,979	2,964	2,166	2,465	3,306	3,290	2,404
93	2,243	3,008	2,994	2,189	2,490	3,339	3,323	2,430
94	2,266	3,038	3,024	2,213	2,515	3,373	3,356	2,456
95	2,288	3,069	3,054	2,237	2,540	3,406	3,390	2,483
96	2,311	3,100	3,084	2,261	2,565	3,440	3,424	2,510
97	2,334	3,131	3,115	2,285	2,591	3,475	3,458	2,537
98	2,358	3,162	3,146	2,310	2,617	3,510	3,493	2,564
99	2,381	3,193	3,178	2,335	2,643	3,545	3,527	2,592

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 $1184	$0	$1184 (Part A deductible)
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $592 a day	[$592] 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 $148 a day	$0	Up to $148 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 $147 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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $1184	$1184 (Part A deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $592 a day	$592 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 $148 a day	Up to $148 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 $147 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 $147 of Medicare Approved Amounts*	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$147 (Part B deductible)	$0
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 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 $1184	$1184 (Part A deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $592 a day	$592 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 $148 a day	Up to $148 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 $147 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 $147 of Medicare Approved Amounts*	$0	$147 (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 $147 of Medicare Approved amounts*	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$147 (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 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 $1184	$1184 (Part A deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $592 a day	$592 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 $148 a day	Up to $148 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 $147 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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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.