Manhattan Life Application Packet

Thank you for your interest in the Manhattan Life Medicare Supplement plan!

This application packet provides you with access to a printable copy of the Enrollment Form and the Outline of Coverage in addition to a link to the Choosing a Medigap Policy Guide.

Should you decide to apply by secure upload/mail/fax/email, the printable application needs to be reviewed and signed by an Agent before it can be submitted to Manhattan Life. You may email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: cs@cda-insurance.com
- Secure File Upload: Click here
- Mail: CDA Insurance LLC
  PO Box 26540
  Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf) Download Policy Outline (.pdf) Download Application (.pdf)

Our website: https://medicare-oregon.com

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

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 $2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2300. 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	1,749	2,317	2,342	1,814	1,471	2,012	2,663	2,690	2,084	1,689
65	1,749	2,317	2,342	1,814	1,471	2,012	2,663	2,690	2,084	1,689
66	1,749	2,317	2,342	1,814	1,471	2,012	2,663	2,690	2,084	1,689
67	1,749	2,317	2,342	1,814	1,471	2,012	2,663	2,690	2,084	1,689
68	1,825	2,409	2,435	1,893	1,534	2,098	2,769	2,800	2,176	1,762
69	1,897	2,502	2,530	1,976	1,598	2,181	2,877	2,909	2,271	1,835
70	1,968	2,592	2,618	2,052	1,659	2,263	2,978	3,010	2,359	1,907
71	2,027	2,675	2,704	2,126	1,720	2,330	3,076	3,108	2,444	1,975
72	2,086	2,760	2,790	2,201	1,780	2,397	3,174	3,207	2,530	2,045
73	2,146	2,844	2,876	2,275	1,840	2,465	3,271	3,306	2,613	2,116
74	2,205	2,930	2,961	2,348	1,900	2,534	3,368	3,405	2,700	2,186
75	2,265	3,017	3,050	2,425	1,963	2,604	3,468	3,506	2,787	2,256
76	2,320	3,109	3,142	2,502	2,030	2,664	3,574	3,612	2,876	2,333
77	2,371	3,202	3,236	2,581	2,097	2,727	3,680	3,721	2,967	2,410
78	2,429	3,299	3,335	2,663	2,168	2,791	3,792	3,833	3,062	2,491
79	2,485	3,397	3,434	2,748	2,239	2,858	3,906	3,948	3,158	2,574
80	2,544	3,499	3,537	2,833	2,312	2,926	4,022	4,064	3,257	2,658
81	2,598	3,605	3,643	2,923	2,392	2,987	4,143	4,188	3,359	2,748
82	2,651	3,713	3,752	3,014	2,472	3,048	4,267	4,312	3,465	2,842
83	2,709	3,825	3,866	3,109	2,557	3,114	4,398	4,443	3,574	2,938
84	2,767	3,941	3,982	3,209	2,644	3,180	4,531	4,577	3,687	3,039
85	2,827	4,059	4,100	3,308	2,732	3,248	4,665	4,715	3,803	3,140
86	2,889	4,182	4,224	3,410	2,822	3,319	4,806	4,855	3,920	3,243
87	2,953	4,307	4,352	3,514	2,915	3,394	4,950	5,002	4,039	3,351
88	3,018	4,436	4,479	3,621	3,009	3,468	5,098	5,151	4,164	3,460
89	3,079	4,558	4,605	3,726	3,101	3,539	5,240	5,292	4,282	3,563
90	3,138	4,679	4,725	3,828	3,190	3,607	5,380	5,432	4,399	3,668
91	3,189	4,792	4,839	3,921	3,277	3,665	5,508	5,561	4,506	3,765
92	3,234	4,896	4,946	4,008	3,355	3,715	5,629	5,684	4,608	3,857
93	3,273	4,994	5,044	4,091	3,430	3,762	5,740	5,798	4,703	3,942
94	3,310	5,093	5,142	4,173	3,506	3,806	5,855	5,912	4,797	4,029
95	3,351	5,194	5,243	4,257	3,583	3,851	5,970	6,028	4,894	4,119
96	3,417	5,296	5,349	4,343	3,654	3,929	6,090	6,147	4,991	4,200
97	3,487	5,403	5,455	4,429	3,728	4,008	6,209	6,269	5,091	4,285
98	3,556	5,512	5,565	4,518	3,803	4,088	6,335	6,395	5,193	4,370
99	3,627	5,622	5,676	4,608	3,878	4,170	6,462	6,525	5,297	4,457

Premium payable other than annual will be determined according to the following factors:

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

There is a one time $25.00 policy fee.
A discount factor of .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	2,012	2,663	2,690	2,084	1,689	2,312	3,061	3,094	2,396	1,942
65	2,012	2,663	2,690	2,084	1,689	2,312	3,061	3,094	2,396	1,942
66	2,012	2,663	2,690	2,084	1,689	2,312	3,061	3,094	2,396	1,942
67	2,012	2,663	2,690	2,084	1,689	2,312	3,061	3,094	2,396	1,942
68	2,098	2,769	2,800	2,176	1,762	2,411	3,183	3,217	2,501	2,026
69	2,181	2,877	2,909	2,271	1,835	2,507	3,307	3,343	2,611	2,110
70	2,263	2,978	3,010	2,359	1,907	2,600	3,423	3,460	2,712	2,191
71	2,330	3,076	3,108	2,444	1,975	2,679	3,535	3,574	2,809	2,270
72	2,397	3,174	3,207	2,530	2,045	2,757	3,647	3,686	2,907	2,350
73	2,465	3,271	3,306	2,613	2,116	2,834	3,758	3,800	3,005	2,433
74	2,534	3,368	3,405	2,700	2,186	2,912	3,871	3,912	3,104	2,512
75	2,604	3,468	3,506	2,787	2,256	2,992	3,988	4,031	3,204	2,594
76	2,664	3,574	3,612	2,876	2,333	3,062	4,108	4,152	3,307	2,683
77	2,727	3,680	3,721	2,967	2,410	3,132	4,229	4,274	3,411	2,770
78	2,791	3,792	3,833	3,062	2,491	3,208	4,360	4,405	3,520	2,862
79	2,858	3,906	3,948	3,158	2,574	3,286	4,489	4,537	3,631	2,958
80	2,926	4,022	4,064	3,257	2,658	3,363	4,622	4,673	3,744	3,055
81	2,987	4,143	4,188	3,359	2,748	3,432	4,762	4,813	3,862	3,160
82	3,048	4,267	4,312	3,465	2,842	3,504	4,905	4,956	3,981	3,266
83	3,114	4,398	4,443	3,574	2,938	3,579	5,054	5,107	4,108	3,379
84	3,180	4,531	4,577	3,687	3,039	3,655	5,207	5,261	4,238	3,493
85	3,248	4,665	4,715	3,803	3,140	3,734	5,364	5,419	4,370	3,610
86	3,319	4,806	4,855	3,920	3,243	3,815	5,524	5,582	4,505	3,729
87	3,394	4,950	5,002	4,039	3,351	3,902	5,691	5,748	4,643	3,850
88	3,468	5,098	5,151	4,164	3,460	3,988	5,860	5,919	4,784	3,977
89	3,539	5,240	5,292	4,282	3,563	4,069	6,021	6,082	4,922	4,096
90	3,607	5,380	5,432	4,399	3,668	4,146	6,181	6,244	5,055	4,215
91	3,665	5,508	5,561	4,506	3,765	4,212	6,332	6,394	5,179	4,328
92	3,715	5,629	5,684	4,608	3,857	4,272	6,470	6,534	5,296	4,433
93	3,762	5,740	5,798	4,703	3,942	4,323	6,598	6,664	5,404	4,532
94	3,806	5,855	5,912	4,797	4,029	4,375	6,729	6,794	5,514	4,632
95	3,851	5,970	6,028	4,894	4,119	4,427	6,861	6,927	5,624	4,734
96	3,929	6,090	6,147	4,991	4,200	4,516	6,999	7,067	5,737	4,827
97	4,008	6,209	6,269	5,091	4,285	4,606	7,139	7,208	5,852	4,925
98	4,088	6,335	6,395	5,193	4,370	4,699	7,282	7,351	5,969	5,023
99	4,170	6,462	6,525	5,297	4,457	4,792	7,428	7,499	6,088	5,124

Premium payable other than annual will be determined according to the following factors:

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

There is a one time $25.00 policy fee.
A discount factor of 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	1,638	2,171	2,194	1,699	1,378	1,885	2,495	2,520	1,953	1,582
65	1,638	2,171	2,194	1,699	1,378	1,885	2,495	2,520	1,953	1,582
66	1,638	2,171	2,194	1,699	1,378	1,885	2,495	2,520	1,953	1,582
67	1,638	2,171	2,194	1,699	1,378	1,885	2,495	2,520	1,953	1,582
68	1,710	2,257	2,281	1,774	1,437	1,965	2,594	2,623	2,039	1,651
69	1,777	2,344	2,370	1,851	1,497	2,043	2,695	2,725	2,127	1,719
70	1,844	2,428	2,453	1,922	1,554	2,120	2,790	2,820	2,210	1,786
71	1,899	2,506	2,533	1,992	1,611	2,183	2,882	2,912	2,290	1,850
72	1,954	2,585	2,614	2,062	1,668	2,245	2,973	3,005	2,370	1,916
73	2,011	2,665	2,694	2,132	1,724	2,310	3,064	3,097	2,448	1,982
74	2,066	2,745	2,774	2,200	1,780	2,374	3,155	3,190	2,529	2,048
75	2,122	2,827	2,857	2,272	1,839	2,439	3,249	3,284	2,611	2,114
76	2,173	2,913	2,943	2,344	1,902	2,496	3,348	3,384	2,694	2,186
77	2,221	2,999	3,031	2,418	1,964	2,555	3,448	3,486	2,779	2,258
78	2,276	3,091	3,124	2,495	2,031	2,615	3,553	3,591	2,868	2,334
79	2,328	3,183	3,217	2,575	2,098	2,677	3,660	3,699	2,958	2,411
80	2,383	3,278	3,313	2,654	2,166	2,741	3,768	3,807	3,051	2,490
81	2,434	3,378	3,413	2,739	2,241	2,798	3,881	3,923	3,147	2,575
82	2,484	3,478	3,515	2,824	2,316	2,855	3,998	4,040	3,246	2,663
83	2,538	3,583	3,621	2,913	2,396	2,917	4,120	4,163	3,348	2,753
84	2,593	3,692	3,731	3,006	2,477	2,979	4,244	4,288	3,454	2,847
85	2,649	3,803	3,841	3,099	2,560	3,043	4,371	4,417	3,563	2,941
86	2,706	3,918	3,957	3,194	2,644	3,110	4,503	4,549	3,672	3,038
87	2,766	4,035	4,077	3,292	2,731	3,180	4,637	4,686	3,784	3,139
88	2,828	4,155	4,196	3,393	2,819	3,249	4,776	4,826	3,901	3,241
89	2,884	4,270	4,314	3,491	2,905	3,315	4,909	4,958	4,011	3,338
90	2,940	4,383	4,427	3,586	2,989	3,379	5,040	5,089	4,121	3,436
91	2,988	4,489	4,534	3,673	3,070	3,434	5,160	5,210	4,221	3,527
92	3,030	4,587	4,633	3,755	3,143	3,481	5,273	5,325	4,317	3,613
93	3,066	4,679	4,725	3,832	3,213	3,524	5,377	5,432	4,406	3,693
94	3,101	4,771	4,818	3,910	3,284	3,565	5,485	5,538	4,494	3,774
95	3,139	4,866	4,912	3,988	3,357	3,608	5,593	5,647	4,585	3,859
96	3,201	4,962	5,012	4,069	3,423	3,681	5,705	5,759	4,676	3,935
97	3,266	5,061	5,110	4,149	3,492	3,755	5,817	5,873	4,770	4,014
98	3,331	5,164	5,214	4,233	3,563	3,830	5,935	5,991	4,865	4,094
99	3,398	5,267	5,318	4,317	3,633	3,906	6,054	6,113	4,963	4,176

Premium payable other than annual will be determined according to the following factors:

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

There is a one time $25.00 policy fee.
A discount factor of .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	1,885	2,495	2,520	1,953	1,582	2,166	2,868	2,899	2,245	1,819
65	1,885	2,495	2,520	1,953	1,582	2,166	2,868	2,899	2,245	1,819
66	1,885	2,495	2,520	1,953	1,582	2,166	2,868	2,899	2,245	1,819
67	1,885	2,495	2,520	1,953	1,582	2,166	2,868	2,899	2,245	1,819
68	1,965	2,594	2,623	2,039	1,651	2,259	2,982	3,014	2,343	1,898
69	2,043	2,695	2,725	2,127	1,719	2,349	3,098	3,132	2,446	1,977
70	2,120	2,790	2,820	2,210	1,786	2,436	3,207	3,241	2,541	2,052
71	2,183	2,882	2,912	2,290	1,850	2,510	3,312	3,348	2,632	2,126
72	2,245	2,973	3,005	2,370	1,916	2,583	3,417	3,453	2,723	2,202
73	2,310	3,064	3,097	2,448	1,982	2,655	3,521	3,560	2,815	2,279
74	2,374	3,155	3,190	2,529	2,048	2,728	3,627	3,665	2,908	2,353
75	2,439	3,249	3,284	2,611	2,114	2,803	3,736	3,776	3,002	2,431
76	2,496	3,348	3,384	2,694	2,186	2,868	3,848	3,889	3,098	2,513
77	2,555	3,448	3,486	2,779	2,258	2,934	3,962	4,004	3,196	2,595
78	2,615	3,553	3,591	2,868	2,334	3,006	4,084	4,127	3,297	2,682
79	2,677	3,660	3,699	2,958	2,411	3,079	4,205	4,251	3,402	2,771
80	2,741	3,768	3,807	3,051	2,490	3,151	4,330	4,378	3,507	2,862
81	2,798	3,881	3,923	3,147	2,575	3,216	4,462	4,509	3,618	2,960
82	2,855	3,998	4,040	3,246	2,663	3,282	4,595	4,643	3,730	3,060
83	2,917	4,120	4,163	3,348	2,753	3,353	4,735	4,785	3,848	3,166
84	2,979	4,244	4,288	3,454	2,847	3,424	4,878	4,929	3,970	3,273
85	3,043	4,371	4,417	3,563	2,941	3,498	5,025	5,077	4,094	3,382
86	3,110	4,503	4,549	3,672	3,038	3,574	5,175	5,230	4,220	3,493
87	3,180	4,637	4,686	3,784	3,139	3,655	5,331	5,385	4,349	3,607
88	3,249	4,776	4,826	3,901	3,241	3,736	5,490	5,546	4,482	3,726
89	3,315	4,909	4,958	4,011	3,338	3,812	5,641	5,698	4,611	3,838
90	3,379	5,040	5,089	4,121	3,436	3,884	5,790	5,850	4,736	3,949
91	3,434	5,160	5,210	4,221	3,527	3,946	5,932	5,990	4,852	4,055
92	3,481	5,273	5,325	4,317	3,613	4,002	6,061	6,121	4,962	4,153
93	3,524	5,377	5,432	4,406	3,693	4,050	6,181	6,243	5,062	4,245
94	3,565	5,485	5,538	4,494	3,774	4,098	6,304	6,365	5,166	4,340
95	3,608	5,593	5,647	4,585	3,859	4,147	6,428	6,490	5,269	4,435
96	3,681	5,705	5,759	4,676	3,935	4,231	6,557	6,621	5,375	4,522
97	3,755	5,817	5,873	4,770	4,014	4,315	6,688	6,752	5,482	4,614
98	3,830	5,935	5,991	4,865	4,094	4,402	6,822	6,887	5,592	4,705
99	3,906	6,054	6,113	4,963	4,176	4,489	6,959	7,026	5,703	4,801

Premium payable other than annual will be determined according to the following factors:

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

There is a one time $25.00 policy fee.
A discount factor of .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	All but $1364	$0	$1364 (Part A deductible)
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	$0	Up to $170.50 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 $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $1364	$1364 (Part A deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 $185 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 $185 of Medicare Approved Amounts*	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$185 (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 $1364	$1364 (Part A deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 $185 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 $185 of Medicare Approved Amounts*	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$185 (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 $1364	$1364 (Part A deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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.

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

*Once you have been billed $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $1364	$1364 (Part A deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 $185 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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts*	$0	$0	$185 (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 $185 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $185 (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.