Manhattan Life Application Packet

Thank you for your interest in applying for 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 upload, 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: http://www.medicare-colorado.net

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 four of the eleven plans available. **In Colorado, it is a requirement that all Plans offered by Central United Life Insurance Company are available to under age 65 Medicare qualified individuals.**

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 COLORADO ZIP CODES
800-802

Attained	Female					Male				
Age	Plan A	Plan C	Plan F	Plan G	Plan N	Plan A	Plan C	Plan F	Plan G	Plan N
0-64	2,392	3,209	3,193	2,120	2,412	2,655	3,561	3,545	2,435	2,677
65	1,400	1,877	1,867	1,412	1,312	1,553	2,083	2,074	1,624	1,458
66	1,400	1,877	1,867	1,412	1,312	1,553	2,083	2,074	1,624	1,458
67	1,400	1,877	1,867	1,412	1,312	1,553	2,083	2,074	1,624	1,458
68	1,462	1,960	1,952	1,476	1,382	1,623	2,176	2,167	1,696	1,535
69	1,521	2,040	2,029	1,539	1,447	1,689	2,264	2,252	1,770	1,607
70	1,581	2,121	2,111	1,600	1,515	1,756	2,354	2,342	1,839	1,681
71	1,644	2,205	2,195	1,658	1,585	1,827	2,449	2,437	1,905	1,759
72	1,710	2,294	2,283	1,716	1,656	1,899	2,547	2,534	1,971	1,839
73	1,762	2,363	2,352	1,773	1,715	1,956	2,623	2,610	2,039	1,902
74	1,814	2,434	2,423	1,831	1,774	2,014	2,701	2,689	2,105	1,968
75	1,868	2,507	2,495	1,891	1,833	2,075	2,784	2,769	2,174	2,034
76	1,925	2,581	2,570	1,952	1,895	2,137	2,866	2,853	2,244	2,103
77	1,983	2,658	2,646	2,013	1,959	2,201	2,952	2,938	2,314	2,175
78	2,043	2,739	2,726	2,079	2,025	2,267	3,042	3,025	2,390	2,248
79	2,103	2,822	2,808	2,144	2,094	2,336	3,132	3,117	2,465	2,323
80	2,167	2,907	2,892	2,211	2,164	2,406	3,225	3,210	2,542	2,400
81	2,221	2,979	2,963	2,282	2,222	2,465	3,308	3,290	2,623	2,466
82	2,265	3,038	3,024	2,353	2,272	2,514	3,372	3,356	2,705	2,522
83	2,311	3,100	3,083	2,429	2,322	2,566	3,440	3,424	2,792	2,577
84	2,357	3,162	3,146	2,506	2,375	2,616	3,509	3,491	2,881	2,635
85	2,392	3,209	3,193	2,584	2,412	2,655	3,561	3,545	2,970	2,677
86	2,429	3,258	3,241	2,665	2,453	2,696	3,615	3,598	3,063	2,723
87	2,453	3,290	3,272	2,747	2,480	2,722	3,650	3,633	3,158	2,751
88	2,477	3,322	3,306	2,832	2,506	2,750	3,688	3,669	3,255	2,782
89	2,502	3,356	3,339	2,913	2,534	2,777	3,725	3,706	3,348	2,812
90	2,527	3,389	3,372	2,993	2,562	2,805	3,762	3,744	3,440	2,843
91	2,553	3,424	3,406	3,067	2,589	2,834	3,799	3,781	3,525	2,874
92	2,577	3,457	3,440	3,136	2,619	2,862	3,838	3,818	3,606	2,907
93	2,603	3,491	3,475	3,201	2,646	2,890	3,875	3,857	3,680	2,938
94	2,630	3,526	3,509	3,267	2,676	2,919	3,914	3,895	3,754	2,970
95	2,655	3,561	3,545	3,333	2,704	2,948	3,954	3,934	3,831	3,002
96	2,684	3,598	3,580	3,401	2,734	2,978	3,992	3,974	3,908	3,033
97	2,709	3,633	3,617	3,468	2,763	3,008	4,032	4,014	3,987	3,067
98	2,736	3,669	3,652	3,537	2,795	3,038	4,073	4,054	4,066	3,101
99	2,763	3,706	3,688	3,609	2,823	3,069	4,115	4,095	4,147	3,135

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

SemiAnnual 1/2 **Quarterly 1/4** **Monthly 1/12**

There is a one time $25.00 policy fee.
A discount factor of .93 is applied for household discount applicants.

THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN COLORADO ZIP CODES
800-802

Attained	Female					Male				
Age	Plan A	Plan C	Plan F	Plan G	Plan N	Plan A	Plan C	Plan F	Plan G	Plan N
0-64	2,661	3,568	3,551	2,435	2,682	2,954	3,961	3,941	2,800	2,978
65	1,555	2,086	2,076	1,624	1,461	1,727	2,317	2,306	1,866	1,620
66	1,555	2,086	2,076	1,624	1,461	1,727	2,317	2,306	1,866	1,620
67	1,555	2,086	2,076	1,624	1,461	1,727	2,317	2,306	1,866	1,620
68	1,625	2,180	2,169	1,696	1,538	1,805	2,419	2,408	1,949	1,706
69	1,692	2,268	2,257	1,770	1,609	1,878	2,518	2,506	2,034	1,786
70	1,759	2,358	2,346	1,839	1,683	1,952	2,619	2,606	2,113	1,868
71	1,829	2,453	2,441	1,905	1,762	2,030	2,723	2,709	2,190	1,956
72	1,902	2,552	2,538	1,971	1,844	2,113	2,832	2,817	2,267	2,045
73	1,959	2,627	2,615	2,039	1,906	2,175	2,916	2,903	2,342	2,115
74	2,018	2,705	2,693	2,105	1,971	2,240	3,004	2,989	2,419	2,188
75	2,079	2,788	2,774	2,174	2,039	2,307	3,094	3,079	2,499	2,263
76	2,141	2,870	2,858	2,244	2,107	2,377	3,187	3,171	2,579	2,340
77	2,205	2,958	2,943	2,314	2,179	2,449	3,283	3,267	2,661	2,418
78	2,271	3,047	3,031	2,390	2,252	2,522	3,382	3,364	2,746	2,499
79	2,340	3,139	3,123	2,465	2,327	2,597	3,483	3,465	2,834	2,584
80	2,410	3,231	3,216	2,542	2,406	2,674	3,587	3,571	2,921	2,670
81	2,471	3,313	3,295	2,623	2,472	2,742	3,676	3,659	3,015	2,743
82	2,520	3,379	3,363	2,705	2,527	2,796	3,750	3,731	3,109	2,805
83	2,570	3,445	3,430	2,792	2,583	2,853	3,825	3,807	3,209	2,867
84	2,622	3,514	3,498	2,881	2,639	2,909	3,903	3,883	3,310	2,930
85	2,661	3,568	3,551	2,970	2,682	2,954	3,961	3,941	3,414	2,978
86	2,700	3,622	3,603	3,063	2,727	2,998	4,020	4,000	3,521	3,027
87	2,727	3,657	3,641	3,158	2,758	3,028	4,059	4,039	3,630	3,060
88	2,755	3,695	3,676	3,255	2,786	3,058	4,101	4,081	3,742	3,094
89	2,782	3,730	3,714	3,348	2,817	3,087	4,142	4,122	3,849	3,128
90	2,811	3,768	3,750	3,440	2,849	3,120	4,182	4,163	3,954	3,162
91	2,838	3,807	3,788	3,525	2,880	3,150	4,224	4,204	4,053	3,197
92	2,866	3,843	3,825	3,606	2,911	3,181	4,267	4,246	4,145	3,232
93	2,894	3,883	3,864	3,680	2,943	3,214	4,311	4,289	4,230	3,267
94	2,924	3,920	3,903	3,754	2,975	3,245	4,354	4,332	4,316	3,302
95	2,954	3,961	3,941	3,831	3,008	3,278	4,396	4,374	4,404	3,339
96	2,982	4,000	3,981	3,908	3,040	3,312	4,440	4,419	4,491	3,374
97	3,012	4,039	4,022	3,987	3,074	3,344	4,485	4,463	4,582	3,411
98	3,043	4,081	4,061	4,066	3,108	3,378	4,529	4,508	4,674	3,448
99	3,074	4,122	4,101	4,147	3,140	3,411	4,575	4,552	4,767	3,486

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

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

There is a one time $25.00 policy fee.
A discount factor of .93 is applied for household discount applicants.

THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN COLORADO ZIP CODES ALL EXCEPT
800-802

Attained	Female					Male				
Age	Plan A	Plan C	Plan F	Plan G	Plan N	Plan A	Plan C	Plan F	Plan G	Plan N
0-64	2,197	2,947	2,933	1,947	2,216	2,439	3,271	3,256	2,237	2,459
65	1,286	1,724	1,715	1,297	1,205	1,426	1,913	1,905	1,492	1,339
66	1,286	1,724	1,715	1,297	1,205	1,426	1,913	1,905	1,492	1,339
67	1,286	1,724	1,715	1,297	1,205	1,426	1,913	1,905	1,492	1,339
68	1,343	1,800	1,793	1,355	1,270	1,490	1,999	1,990	1,557	1,410
69	1,397	1,874	1,864	1,414	1,329	1,551	2,079	2,068	1,626	1,476
70	1,452	1,948	1,939	1,469	1,391	1,613	2,163	2,151	1,689	1,544
71	1,510	2,025	2,016	1,523	1,456	1,678	2,249	2,238	1,750	1,616
72	1,571	2,107	2,097	1,576	1,521	1,745	2,340	2,327	1,810	1,689
73	1,618	2,170	2,160	1,628	1,575	1,797	2,409	2,397	1,872	1,747
74	1,667	2,236	2,226	1,681	1,629	1,850	2,481	2,470	1,933	1,808
75	1,716	2,303	2,292	1,737	1,684	1,906	2,557	2,543	1,996	1,869
76	1,768	2,371	2,361	1,793	1,741	1,963	2,633	2,620	2,061	1,932
77	1,822	2,442	2,430	1,849	1,799	2,021	2,712	2,698	2,125	1,998
78	1,876	2,516	2,504	1,910	1,860	2,082	2,794	2,779	2,195	2,065
79	1,932	2,592	2,579	1,969	1,923	2,145	2,877	2,863	2,264	2,134
80	1,990	2,670	2,656	2,031	1,988	2,210	2,962	2,949	2,335	2,205
81	2,040	2,737	2,722	2,096	2,041	2,264	3,038	3,022	2,409	2,265
82	2,081	2,790	2,778	2,161	2,087	2,309	3,098	3,083	2,485	2,316
83	2,123	2,847	2,832	2,231	2,133	2,357	3,160	3,145	2,564	2,367
84	2,165	2,904	2,889	2,301	2,181	2,403	3,223	3,207	2,646	2,420
85	2,197	2,947	2,933	2,373	2,216	2,439	3,271	3,256	2,728	2,459
86	2,231	2,992	2,977	2,448	2,253	2,476	3,321	3,305	2,814	2,501
87	2,253	3,022	3,006	2,523	2,278	2,500	3,353	3,337	2,900	2,527
88	2,275	3,052	3,037	2,602	2,301	2,526	3,388	3,370	2,990	2,556
89	2,298	3,083	3,067	2,676	2,327	2,551	3,421	3,404	3,075	2,583
90	2,321	3,112	3,098	2,749	2,354	2,577	3,456	3,439	3,160	2,611
91	2,345	3,145	3,129	2,817	2,378	2,603	3,489	3,473	3,238	2,640
92	2,367	3,176	3,160	2,881	2,406	2,629	3,525	3,507	3,312	2,670
93	2,391	3,207	3,192	2,940	2,430	2,655	3,559	3,543	3,380	2,698
94	2,416	3,239	3,223	3,001	2,458	2,681	3,595	3,577	3,448	2,728
95	2,439	3,271	3,256	3,062	2,484	2,708	3,632	3,613	3,519	2,758
96	2,465	3,305	3,288	3,124	2,511	2,735	3,667	3,651	3,590	2,786
97	2,489	3,337	3,322	3,186	2,538	2,763	3,704	3,687	3,662	2,817
98	2,513	3,370	3,354	3,249	2,567	2,790	3,741	3,724	3,735	2,848
99	2,538	3,404	3,388	3,315	2,593	2,819	3,780	3,761	3,809	2,879

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

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

There is a one time $25.00 policy fee.
A discount factor of .93 is applied for household discount applicants.

THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN COLORADO ZIP CODES ALL EXCEPT
800-802

Attained	Female					Male				
Age	Plan A	Plan C	Plan F	Plan G	Plan N	Plan A	Plan C	Plan F	Plan G	Plan N
0-64	2,444	3,277	3,261	2,237	2,464	2,713	3,638	3,620	2,572	2,735
65	1,428	1,916	1,907	1,492	1,342	1,586	2,128	2,118	1,714	1,488
66	1,428	1,916	1,907	1,492	1,342	1,586	2,128	2,118	1,714	1,488
67	1,428	1,916	1,907	1,492	1,342	1,586	2,128	2,118	1,714	1,488
68	1,493	2,003	1,993	1,557	1,412	1,658	2,222	2,212	1,791	1,567
69	1,554	2,083	2,073	1,626	1,478	1,725	2,313	2,301	1,869	1,641
70	1,616	2,166	2,155	1,689	1,546	1,793	2,406	2,393	1,941	1,716
71	1,680	2,253	2,242	1,750	1,618	1,865	2,501	2,489	2,011	1,797
72	1,747	2,344	2,331	1,810	1,694	1,941	2,602	2,588	2,082	1,879
73	1,799	2,413	2,402	1,872	1,751	1,998	2,678	2,666	2,151	1,943
74	1,854	2,485	2,474	1,933	1,810	2,057	2,759	2,745	2,222	2,010
75	1,910	2,561	2,548	1,996	1,872	2,119	2,842	2,828	2,295	2,078
76	1,967	2,636	2,625	2,061	1,936	2,184	2,928	2,913	2,368	2,149
77	2,025	2,717	2,703	2,125	2,001	2,249	3,016	3,001	2,444	2,221
78	2,086	2,799	2,784	2,195	2,068	2,316	3,106	3,090	2,522	2,295
79	2,149	2,883	2,868	2,264	2,138	2,386	3,199	3,183	2,603	2,373
80	2,213	2,967	2,954	2,335	2,210	2,456	3,295	3,280	2,683	2,453
81	2,269	3,043	3,027	2,409	2,270	2,518	3,377	3,360	2,769	2,520
82	2,315	3,104	3,089	2,485	2,321	2,568	3,445	3,427	2,856	2,577
83	2,361	3,164	3,151	2,564	2,372	2,620	3,513	3,497	2,947	2,634
84	2,408	3,228	3,213	2,646	2,424	2,672	3,585	3,566	3,040	2,691
85	2,444	3,277	3,261	2,728	2,464	2,713	3,638	3,620	3,136	2,735
86	2,480	3,327	3,310	2,814	2,505	2,754	3,693	3,674	3,234	2,780
87	2,505	3,359	3,344	2,900	2,533	2,781	3,729	3,710	3,334	2,811
88	2,531	3,394	3,377	2,990	2,559	2,809	3,767	3,749	3,437	2,842
89	2,556	3,426	3,411	3,075	2,588	2,836	3,804	3,786	3,535	2,873
90	2,582	3,461	3,445	3,160	2,616	2,866	3,842	3,824	3,632	2,904
91	2,606	3,497	3,479	3,238	2,645	2,893	3,880	3,861	3,722	2,936
92	2,633	3,530	3,513	3,312	2,673	2,921	3,920	3,900	3,807	2,969
93	2,659	3,566	3,549	3,380	2,703	2,952	3,959	3,939	3,885	3,001
94	2,686	3,601	3,585	3,448	2,733	2,981	3,999	3,979	3,964	3,033
95	2,713	3,638	3,620	3,519	2,763	3,011	4,037	4,018	4,045	3,067
96	2,739	3,674	3,657	3,590	2,792	3,042	4,078	4,059	4,125	3,099
97	2,766	3,710	3,694	3,662	2,823	3,071	4,119	4,099	4,209	3,133
98	2,795	3,749	3,730	3,735	2,854	3,102	4,160	4,140	4,293	3,167
99	2,823	3,786	3,767	3,809	2,884	3,133	4,202	4,181	4,378	3,202

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

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

There is a one time $25.00 policy fee.
A discount factor of .93 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.

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 consecutive days of each trip outside the USA. Emergency care means care needed immediately because of an injury or illness of sudden and unexpected onset.			
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 consecutive days of each trip outside the USA, Emergency care means care needed immediately because of an injury or illness of sudden and unexpected onset.			
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.

PLAN G

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 consecutive days of each trip outside the USA. Emergency care means care needed immediately because of an injury or illness of sudden and unexpected onset. 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.