ManhattanLife Insurance and Annuity Company
Outline of Medicare Supplement Coverage-Cover Page
Benefit Plans A, F, G, and N

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020.

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A." Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F. ManhattanLife Insurance and Annuity Company offers four of the twelve plans available, Plans A, F, G, and N.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants									Medicare first eligible before 2020 only		
	A	B	D	G	G[1]	K	L	M	N	C	F	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Medicare Part B coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓ Copays apply[3]	✓	✓	
Blood (first three pints)	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Part A hospice care coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Skilled nursing facility coinsurance			✓	✓		50%	75%	✓	✓	✓	✓	
Medicare Part A deductible		✓	✓	✓		50%	75%	50%	✓	✓	✓	
Medicare Part B deductible										✓	✓	
Medicare Part B excess charges				✓							✓	
Foreign travel emergency (up to plan limits)			✓	✓				✓	✓	✓	✓	
Out-of-pocket limit in 2024[2]						$7,060[2]	$3,530[2]					

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,800 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.
[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.
[3] Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

MANHATTANLIFE INSURANCE AND ANNUITY COMPANY
ANNUAL PREFERRED ISSUE AGE PREMIUMS
FOR USE IN GEORGIA ZIP CODES
300-303, 311, 313-314, 399

Issue	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	19,699	24,132	19,442	12,858	22,653	27,751	22,358	14,788
65	1,970	2,414	1,944	1,286	2,266	2,776	2,236	1,478
66	1,970	2,414	1,944	1,286	2,266	2,776	2,236	1,478
67	1,970	2,414	1,944	1,286	2,266	2,776	2,236	1,478
68	2,019	2,470	1,974	1,337	2,321	2,838	2,270	1,538
69	2,058	2,512	2,003	1,374	2,368	2,889	2,305	1,581
70	2,100	2,556	2,035	1,411	2,414	2,938	2,338	1,623
71	2,140	2,598	2,064	1,447	2,462	2,988	2,372	1,665
72	2,180	2,642	2,094	1,485	2,508	3,038	2,408	1,707
73	2,250	2,715	2,164	1,520	2,587	3,123	2,490	1,749
74	2,321	2,789	2,235	1,556	2,668	3,208	2,570	1,789
75	2,391	2,864	2,306	1,591	2,747	3,293	2,653	1,831
76	2,460	2,937	2,379	1,626	2,829	3,378	2,733	1,870
77	2,530	3,012	2,447	1,663	2,909	3,463	2,815	1,911
78	2,585	3,090	2,507	1,714	2,973	3,552	2,883	1,971
79	2,641	3,168	2,565	1,765	3,037	3,644	2,949	2,031
80	2,697	3,246	2,623	1,817	3,099	3,735	3,018	2,090
81	2,753	3,323	2,682	1,868	3,165	3,823	3,085	2,149
82	2,806	3,403	2,742	1,920	3,229	3,913	3,153	2,209
83	2,880	3,518	2,835	1,986	3,314	4,046	3,259	2,283
84	2,954	3,635	2,927	2,050	3,397	4,180	3,367	2,359
85	3,028	3,749	3,021	2,117	3,482	4,312	3,474	2,434
86	3,099	3,866	3,113	2,182	3,564	4,445	3,581	2,508
87	3,173	3,982	3,208	2,246	3,649	4,578	3,688	2,584
88	3,248	4,100	3,303	2,313	3,735	4,716	3,799	2,660
89	3,324	4,223	3,402	2,383	3,823	4,858	3,911	2,740
90	3,402	4,350	3,504	2,454	3,912	5,002	4,030	2,823
91	3,483	4,481	3,610	2,528	4,005	5,153	4,151	2,907
92	3,564	4,614	3,716	2,603	4,100	5,306	4,273	2,994
93	3,647	4,753	3,827	2,682	4,196	5,464	4,402	3,084
94	3,735	4,895	3,942	2,762	4,294	5,629	4,535	3,176
95	3,823	5,041	4,060	2,844	4,395	5,798	4,670	3,271
96	3,911	5,192	4,182	2,930	4,500	5,971	4,808	3,369
97	4,005	5,347	4,308	3,018	4,606	6,149	4,953	3,470
98	4,098	5,506	4,437	3,108	4,714	6,334	5,101	3,574
99	4,196	5,672	4,569	3,200	4,826	6,523	5,255	3,681

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 .93 is applied for household discount applicants.
The Early Enrollment Discount, described on page 6, has been applied to these rates.

MANHATTANLIFE INSURANCE AND ANNUITY COMPANY
ANNUAL STANDARD ISSUE AGE PREMIUMS
FOR USE IN GEORGIA ZIP CODES
300-303, 311, 313-314, 399

Issue	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	22,653	27,751	22,358	14,788	26,051	31,916	25,711	17,006
65	2,266	2,776	2,236	1,478	2,605	3,192	2,571	1,700
66	2,266	2,776	2,236	1,478	2,605	3,192	2,571	1,700
67	2,266	2,776	2,236	1,478	2,605	3,192	2,571	1,700
68	2,321	2,838	2,270	1,538	2,671	3,264	2,610	1,768
69	2,368	2,889	2,305	1,581	2,725	3,322	2,650	1,817
70	2,414	2,938	2,338	1,623	2,777	3,379	2,690	1,866
71	2,462	2,988	2,372	1,665	2,830	3,437	2,728	1,916
72	2,508	3,038	2,408	1,707	2,883	3,493	2,769	1,963
73	2,587	3,123	2,490	1,749	2,976	3,592	2,862	2,011
74	2,668	3,208	2,570	1,789	3,069	3,689	2,957	2,057
75	2,747	3,293	2,653	1,831	3,161	3,787	3,050	2,104
76	2,829	3,378	2,733	1,870	3,252	3,884	3,143	2,152
77	2,909	3,463	2,815	1,911	3,345	3,983	3,237	2,199
78	2,973	3,552	2,883	1,971	3,420	4,087	3,315	2,267
79	3,037	3,644	2,949	2,031	3,493	4,189	3,392	2,335
80	3,099	3,735	3,018	2,090	3,566	4,292	3,469	2,403
81	3,165	3,823	3,085	2,149	3,640	4,396	3,548	2,472
82	3,229	3,913	3,153	2,209	3,714	4,500	3,625	2,540
83	3,314	4,046	3,259	2,283	3,809	4,654	3,748	2,626
84	3,397	4,180	3,367	2,359	3,906	4,806	3,872	2,712
85	3,482	4,312	3,474	2,434	4,004	4,960	3,996	2,798
86	3,564	4,445	3,581	2,508	4,100	5,111	4,118	2,885
87	3,649	4,578	3,688	2,584	4,196	5,266	4,242	2,971
88	3,735	4,716	3,799	2,660	4,296	5,424	4,369	3,059
89	3,823	4,858	3,911	2,740	4,396	5,584	4,499	3,151
90	3,912	5,002	4,030	2,823	4,500	5,752	4,634	3,246
91	4,005	5,153	4,151	2,907	4,606	5,926	4,773	3,342
92	4,100	5,306	4,273	2,994	4,715	6,103	4,915	3,444
93	4,196	5,464	4,402	3,084	4,826	6,284	5,062	3,546
94	4,294	5,629	4,535	3,176	4,939	6,474	5,214	3,653
95	4,395	5,798	4,670	3,271	5,056	6,666	5,371	3,762
96	4,500	5,971	4,808	3,369	5,173	6,865	5,531	3,875
97	4,606	6,149	4,953	3,470	5,295	7,070	5,698	3,990
98	4,714	6,334	5,101	3,574	5,419	7,284	5,866	4,110
99	4,826	6,523	5,255	3,681	5,548	7,501	6,042	4,232

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 .93 is applied for household discount applicants.
The Early Enrollment Discount, described on page 6, has been applied to these rates.

MANHATTANLIFE INSURANCE AND ANNUITY COMPANY
ANNUAL PREFERRED ISSUE AGE PREMIUMS
FOR USE IN GEORGIA ZIP CODES ALL EXCEPT
300-303, 311, 313-314, 399

Issue	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	17,101	20,950	16,878	11,163	19,665	24,092	19,410	12,838
65	1,710	2,096	1,687	1,116	1,967	2,410	1,941	1,283
66	1,710	2,096	1,687	1,116	1,967	2,410	1,941	1,283
67	1,710	2,096	1,687	1,116	1,967	2,410	1,941	1,283
68	1,753	2,144	1,714	1,161	2,015	2,464	1,970	1,335
69	1,787	2,180	1,739	1,193	2,056	2,508	2,001	1,372
70	1,823	2,219	1,766	1,225	2,096	2,551	2,030	1,409
71	1,858	2,255	1,792	1,256	2,137	2,594	2,060	1,446
72	1,893	2,293	1,818	1,289	2,177	2,637	2,090	1,482
73	1,954	2,357	1,879	1,319	2,246	2,711	2,161	1,518
74	2,015	2,421	1,940	1,351	2,316	2,785	2,231	1,553
75	2,075	2,486	2,002	1,381	2,385	2,859	2,303	1,589
76	2,135	2,550	2,065	1,412	2,456	2,932	2,372	1,623
77	2,196	2,615	2,124	1,444	2,526	3,007	2,443	1,659
78	2,244	2,683	2,176	1,488	2,581	3,083	2,503	1,711
79	2,293	2,750	2,227	1,533	2,636	3,163	2,560	1,763
80	2,342	2,818	2,277	1,578	2,691	3,242	2,620	1,815
81	2,390	2,885	2,328	1,622	2,748	3,319	2,678	1,865
82	2,436	2,955	2,380	1,667	2,803	3,397	2,737	1,917
83	2,500	3,054	2,461	1,724	2,877	3,512	2,829	1,982
84	2,564	3,155	2,541	1,780	2,949	3,628	2,923	2,048
85	2,628	3,255	2,623	1,838	3,023	3,744	3,016	2,113
86	2,690	3,356	2,703	1,894	3,094	3,859	3,109	2,177
87	2,755	3,457	2,785	1,950	3,168	3,974	3,202	2,244
88	2,820	3,560	2,868	2,008	3,242	4,094	3,298	2,309
89	2,886	3,666	2,954	2,069	3,319	4,217	3,395	2,379
90	2,954	3,776	3,042	2,131	3,396	4,343	3,499	2,451
91	3,023	3,890	3,134	2,195	3,477	4,474	3,603	2,524
92	3,094	4,005	3,226	2,259	3,559	4,606	3,710	2,599
93	3,166	4,126	3,323	2,328	3,643	4,743	3,821	2,677
94	3,242	4,249	3,422	2,398	3,728	4,887	3,937	2,757
95	3,319	4,377	3,525	2,469	3,816	5,033	4,054	2,840
96	3,395	4,507	3,631	2,544	3,907	5,183	4,174	2,925
97	3,477	4,642	3,740	2,620	3,998	5,338	4,300	3,012
98	3,557	4,780	3,852	2,698	4,092	5,498	4,429	3,102
99	3,643	4,924	3,967	2,778	4,189	5,663	4,562	3,196

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

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

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300-303, 311, 313-314, 399

Issue	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	19,665	24,092	19,410	12,838	22,616	27,707	22,321	14,764
65	1,967	2,410	1,941	1,283	2,262	2,771	2,232	1,476
66	1,967	2,410	1,941	1,283	2,262	2,771	2,232	1,476
67	1,967	2,410	1,941	1,283	2,262	2,771	2,232	1,476
68	2,015	2,464	1,970	1,335	2,319	2,834	2,266	1,535
69	2,056	2,508	2,001	1,372	2,365	2,884	2,300	1,578
70	2,096	2,551	2,030	1,409	2,411	2,933	2,335	1,620
71	2,137	2,594	2,060	1,446	2,457	2,984	2,368	1,663
72	2,177	2,637	2,090	1,482	2,503	3,032	2,404	1,704
73	2,246	2,711	2,161	1,518	2,583	3,118	2,485	1,746
74	2,316	2,785	2,231	1,553	2,664	3,203	2,567	1,785
75	2,385	2,859	2,303	1,589	2,744	3,287	2,648	1,826
76	2,456	2,932	2,372	1,623	2,823	3,372	2,729	1,868
77	2,526	3,007	2,443	1,659	2,904	3,458	2,810	1,909
78	2,581	3,083	2,503	1,711	2,969	3,548	2,878	1,968
79	2,636	3,163	2,560	1,763	3,032	3,636	2,944	2,027
80	2,691	3,242	2,620	1,815	3,096	3,726	3,011	2,086
81	2,748	3,319	2,678	1,865	3,160	3,816	3,080	2,146
82	2,803	3,397	2,737	1,917	3,224	3,907	3,147	2,205
83	2,877	3,512	2,829	1,982	3,307	4,040	3,254	2,280
84	2,949	3,628	2,923	2,048	3,391	4,172	3,361	2,354
85	3,023	3,744	3,016	2,113	3,476	4,306	3,469	2,429
86	3,094	3,859	3,109	2,177	3,559	4,437	3,575	2,504
87	3,168	3,974	3,202	2,244	3,643	4,572	3,682	2,579
88	3,242	4,094	3,298	2,309	3,730	4,708	3,793	2,656
89	3,319	4,217	3,395	2,379	3,816	4,847	3,906	2,736
90	3,396	4,343	3,499	2,451	3,907	4,994	4,023	2,818
91	3,477	4,474	3,603	2,524	3,998	5,144	4,144	2,902
92	3,559	4,606	3,710	2,599	4,093	5,299	4,267	2,990
93	3,643	4,743	3,821	2,677	4,189	5,456	4,395	3,079
94	3,728	4,887	3,937	2,757	4,288	5,620	4,527	3,171
95	3,816	5,033	4,054	2,840	4,389	5,787	4,663	3,266
96	3,907	5,183	4,174	2,925	4,491	5,960	4,802	3,364
97	3,998	5,338	4,300	3,012	4,597	6,138	4,946	3,464
98	4,092	5,498	4,429	3,102	4,704	6,323	5,092	3,568
99	4,189	5,663	4,562	3,196	4,817	6,512	5,246	3,674

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

There is a one-time $25.00 policy fee.
A discount factor of .93 is applied for household discount applicants.
The Early Enrollment Discount, described on page 6, has been applied to these rates.

PREMIUM INFORMATION

ManhattanLife Insurance and Annuity 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 Issue age, underwriting class, and state of residence. We will give You advance written notice as required by Your state prior to any premium change.

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 ManhattanLife Insurance and Annuity 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 ManhattanLife Insurance and Annuity 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 services 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 $1632	$0	$1632 (Part A deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 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			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ 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 $240 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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $240 of Medicare Approved Amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

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 $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/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 $240 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 $240 of Medicare Approved Amounts*	$0	$240 (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 $240 of Medicare Approved amounts*	$0	$240 (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 $240 of Medicare Approved Amounts*	$0	$240 (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 $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ 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 $240 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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ 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 $240 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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $240 (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.