

**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 <sup>1</sup>	K	L	M		C	F	F <sup>1</sup>
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 <sup>3</sup>	✓	✓	
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 <sup>2</sup>						\$7,060 <sup>2</sup>	\$3,530 <sup>2</sup>					

<sup>1</sup> 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.

<sup>2</sup> 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.

<sup>3</sup> 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 ATTAINED AGE PREMIUMS**  
**FOR USE IN MICHIGAN ZIP CODES**  
**490-491, 493-499**

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,479	1,923	1,493	1,108	1,701	2,211	1,718	1,274
66	1,479	1,923	1,493	1,108	1,701	2,211	1,718	1,274
67	1,479	1,923	1,493	1,108	1,701	2,211	1,718	1,274
68	1,482	1,959	1,498	1,139	1,705	2,252	1,723	1,309
69	1,533	2,023	1,547	1,173	1,761	2,327	1,779	1,349
70	1,583	2,088	1,600	1,209	1,821	2,403	1,838	1,390
71	1,637	2,157	1,653	1,260	1,881	2,480	1,900	1,448
72	1,692	2,223	1,709	1,310	1,947	2,556	1,965	1,508
73	1,749	2,290	1,766	1,361	2,010	2,634	2,032	1,566
74	1,814	2,380	1,832	1,419	2,086	2,737	2,108	1,631
75	1,888	2,486	1,908	1,485	2,172	2,857	2,195	1,707
76	1,957	2,583	1,977	1,540	2,251	2,971	2,275	1,771
77	2,038	2,687	2,059	1,595	2,344	3,090	2,367	1,834
78	2,127	2,797	2,149	1,653	2,446	3,216	2,471	1,900
79	2,226	2,915	2,248	1,711	2,560	3,354	2,586	1,967
80	2,335	3,041	2,359	1,778	2,685	3,498	2,712	2,044
81	2,454	3,175	2,479	1,874	2,822	3,650	2,850	2,154
82	2,585	3,316	2,610	1,976	2,972	3,811	3,003	2,274
83	2,725	3,465	2,753	2,090	3,133	3,984	3,165	2,402
84	2,879	3,623	2,908	2,211	3,311	4,166	3,344	2,543
85	3,046	3,792	3,076	2,345	3,502	4,361	3,538	2,696
86	3,207	3,954	3,238	2,475	3,687	4,547	3,724	2,847
87	3,375	4,126	3,408	2,612	3,883	4,745	3,920	3,003
88	3,545	4,308	3,581	2,749	4,077	4,956	4,118	3,164
89	3,717	4,505	3,753	2,890	4,273	5,181	4,318	3,324
90	3,887	4,690	3,927	3,030	4,470	5,393	4,516	3,485
91	4,048	4,862	4,089	3,162	4,655	5,592	4,703	3,635
92	4,206	5,041	4,250	3,292	4,838	5,796	4,887	3,786
93	4,364	5,204	4,408	3,421	5,018	5,984	5,068	3,934
94	4,516	5,367	4,562	3,547	5,196	6,173	5,247	4,079
95	4,666	5,530	4,713	3,670	5,365	6,361	5,420	4,220
96	4,767	5,647	4,816	3,751	5,483	6,493	5,540	4,313
97	4,863	5,760	4,912	3,826	5,593	6,623	5,650	4,400
98	4,956	5,869	5,005	3,898	5,699	6,749	5,757	4,483
99	5,045	5,974	5,095	3,969	5,802	6,870	5,861	4,565

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

Semi Annual  
1/2

Quarterly  
1/4

Monthly  
1/12

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

**MANHATTANLIFE INSURANCE AND ANNUITY COMPANY**  
**ANNUAL STANDARD ATTAINED AGE PREMIUMS**  
**FOR USE IN MICHIGAN ZIP CODES**  
**490-491, 493-499**

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,701	2,211	1,718	1,274	1,956	2,544	1,975	1,466
66	1,701	2,211	1,718	1,274	1,956	2,544	1,975	1,466
67	1,701	2,211	1,718	1,274	1,956	2,544	1,975	1,466
68	1,705	2,252	1,723	1,309	1,961	2,590	1,982	1,506
69	1,761	2,327	1,779	1,349	2,024	2,677	2,046	1,551
70	1,821	2,403	1,838	1,390	2,094	2,763	2,114	1,600
71	1,881	2,480	1,900	1,448	2,165	2,851	2,185	1,666
72	1,947	2,556	1,965	1,508	2,240	2,941	2,261	1,733
73	2,010	2,634	2,032	1,566	2,314	3,029	2,336	1,800
74	2,086	2,737	2,108	1,631	2,399	3,148	2,423	1,876
75	2,172	2,857	2,195	1,707	2,499	3,287	2,524	1,963
76	2,251	2,971	2,275	1,771	2,589	3,417	2,615	2,036
77	2,344	3,090	2,367	1,834	2,695	3,553	2,724	2,110
78	2,446	3,216	2,471	1,900	2,814	3,699	2,842	2,185
79	2,560	3,354	2,586	1,967	2,943	3,856	2,973	2,261
80	2,685	3,498	2,712	2,044	3,088	4,023	3,120	2,351
81	2,822	3,650	2,850	2,154	3,245	4,198	3,279	2,478
82	2,972	3,811	3,003	2,274	3,418	4,383	3,452	2,614
83	3,133	3,984	3,165	2,402	3,604	4,581	3,641	2,763
84	3,311	4,166	3,344	2,543	3,808	4,792	3,846	2,925
85	3,502	4,361	3,538	2,696	4,027	5,014	4,067	3,101
86	3,687	4,547	3,724	2,847	4,239	5,229	4,284	3,274
87	3,883	4,745	3,920	3,003	4,462	5,457	4,508	3,454
88	4,077	4,956	4,118	3,164	4,688	5,699	4,736	3,636
89	4,273	5,181	4,318	3,324	4,914	5,957	4,963	3,822
90	4,470	5,393	4,516	3,485	5,142	6,203	5,194	4,008
91	4,655	5,592	4,703	3,635	5,354	6,430	5,408	4,182
92	4,838	5,796	4,887	3,786	5,563	6,666	5,620	4,353
93	5,018	5,984	5,068	3,934	5,771	6,882	5,829	4,524
94	5,196	6,173	5,247	4,079	5,973	7,099	6,033	4,691
95	5,365	6,361	5,420	4,220	6,171	7,314	6,233	4,854
96	5,483	6,493	5,540	4,313	6,307	7,467	6,370	4,961
97	5,593	6,623	5,650	4,400	6,432	7,616	6,497	5,060
98	5,699	6,749	5,757	4,483	6,554	7,762	6,620	5,156
99	5,802	6,870	5,861	4,565	6,672	7,901	6,740	5,248

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

Semi Annual  
1/2

Quarterly  
1/4

Monthly  
1/12

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

**MANHATTANLIFE INSURANCE AND ANNUITY COMPANY**  
**ANNUAL PREFERRED ATTAINED AGE PREMIUMS**  
**FOR USE IN MICHIGAN ZIP CODES**  
**486-489, 492**

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,597	2,076	1,612	1,196	1,836	2,387	1,854	1,376
66	1,597	2,076	1,612	1,196	1,836	2,387	1,854	1,376
67	1,597	2,076	1,612	1,196	1,836	2,387	1,854	1,376
68	1,600	2,115	1,617	1,229	1,841	2,431	1,860	1,414
69	1,655	2,184	1,670	1,266	1,901	2,512	1,921	1,456
70	1,709	2,254	1,727	1,305	1,966	2,594	1,985	1,500
71	1,767	2,328	1,784	1,360	2,031	2,677	2,051	1,564
72	1,827	2,400	1,845	1,415	2,101	2,760	2,121	1,628
73	1,888	2,472	1,907	1,470	2,170	2,843	2,194	1,690
74	1,958	2,570	1,978	1,531	2,252	2,955	2,275	1,760
75	2,039	2,684	2,060	1,603	2,345	3,085	2,369	1,843
76	2,113	2,788	2,135	1,663	2,430	3,207	2,456	1,911
77	2,200	2,900	2,223	1,721	2,531	3,335	2,556	1,980
78	2,296	3,019	2,320	1,784	2,641	3,472	2,668	2,051
79	2,404	3,147	2,427	1,847	2,764	3,620	2,792	2,123
80	2,520	3,283	2,547	1,920	2,898	3,776	2,928	2,207
81	2,650	3,428	2,676	2,023	3,047	3,941	3,077	2,326
82	2,791	3,580	2,818	2,134	3,208	4,114	3,241	2,455
83	2,942	3,741	2,972	2,256	3,382	4,301	3,417	2,594
84	3,108	3,911	3,139	2,387	3,574	4,497	3,610	2,746
85	3,288	4,094	3,321	2,532	3,780	4,708	3,820	2,911
86	3,462	4,268	3,496	2,671	3,981	4,909	4,020	3,073
87	3,643	4,455	3,679	2,820	4,191	5,122	4,232	3,242
88	3,827	4,651	3,866	2,968	4,401	5,350	4,445	3,415
89	4,013	4,863	4,052	3,120	4,613	5,593	4,662	3,588
90	4,196	5,064	4,239	3,271	4,826	5,822	4,875	3,762
91	4,370	5,249	4,415	3,413	5,026	6,036	5,077	3,924
92	4,541	5,442	4,588	3,554	5,223	6,257	5,275	4,087
93	4,711	5,618	4,759	3,693	5,417	6,460	5,471	4,247
94	4,875	5,794	4,925	3,829	5,609	6,664	5,664	4,403
95	5,037	5,970	5,088	3,962	5,792	6,867	5,851	4,556
96	5,146	6,096	5,199	4,049	5,919	7,009	5,981	4,656
97	5,250	6,219	5,303	4,131	6,038	7,150	6,099	4,750
98	5,350	6,336	5,404	4,209	6,152	7,286	6,215	4,839
99	5,446	6,450	5,501	4,285	6,263	7,417	6,327	4,928

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

Semi Annual  
1/2

Quarterly  
1/4

Monthly  
1/12

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

**MANHATTANLIFE INSURANCE AND ANNUITY COMPANY**  
**ANNUAL STANDARD ATTAINED AGE PREMIUMS**  
**FOR USE IN MICHIGAN ZIP CODES**  
**486-489, 492**

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,836	2,387	1,854	1,376	2,112	2,746	2,132	1,583
66	1,836	2,387	1,854	1,376	2,112	2,746	2,132	1,583
67	1,836	2,387	1,854	1,376	2,112	2,746	2,132	1,583
68	1,841	2,431	1,860	1,414	2,117	2,796	2,139	1,625
69	1,901	2,512	1,921	1,456	2,185	2,890	2,209	1,675
70	1,966	2,594	1,985	1,500	2,260	2,983	2,282	1,727
71	2,031	2,677	2,051	1,564	2,337	3,078	2,359	1,798
72	2,101	2,760	2,121	1,628	2,418	3,175	2,441	1,871
73	2,170	2,843	2,194	1,690	2,498	3,270	2,521	1,944
74	2,252	2,955	2,275	1,760	2,590	3,398	2,615	2,025
75	2,345	3,085	2,369	1,843	2,698	3,548	2,725	2,119
76	2,430	3,207	2,456	1,911	2,795	3,689	2,823	2,198
77	2,531	3,335	2,556	1,980	2,910	3,836	2,940	2,278
78	2,641	3,472	2,668	2,051	3,038	3,993	3,068	2,359
79	2,764	3,620	2,792	2,123	3,177	4,163	3,209	2,441
80	2,898	3,776	2,928	2,207	3,334	4,343	3,368	2,538
81	3,047	3,941	3,077	2,326	3,504	4,532	3,540	2,675
82	3,208	4,114	3,241	2,455	3,690	4,732	3,727	2,822
83	3,382	4,301	3,417	2,594	3,891	4,946	3,930	2,983
84	3,574	4,497	3,610	2,746	4,111	5,173	4,152	3,158
85	3,780	4,708	3,820	2,911	4,347	5,413	4,391	3,348
86	3,981	4,909	4,020	3,073	4,576	5,645	4,625	3,534
87	4,191	5,122	4,232	3,242	4,817	5,891	4,867	3,729
88	4,401	5,350	4,445	3,415	5,061	6,152	5,113	3,925
89	4,613	5,593	4,662	3,588	5,305	6,431	5,358	4,126
90	4,826	5,822	4,875	3,762	5,551	6,697	5,607	4,326
91	5,026	6,036	5,077	3,924	5,780	6,942	5,838	4,514
92	5,223	6,257	5,275	4,087	6,006	7,196	6,067	4,700
93	5,417	6,460	5,471	4,247	6,230	7,430	6,293	4,884
94	5,609	6,664	5,664	4,403	6,448	7,664	6,513	5,064
95	5,792	6,867	5,851	4,556	6,661	7,895	6,729	5,240
96	5,919	7,009	5,981	4,656	6,809	8,061	6,877	5,356
97	6,038	7,150	6,099	4,750	6,944	8,222	7,014	5,463
98	6,152	7,286	6,215	4,839	7,076	8,380	7,147	5,566
99	6,263	7,417	6,327	4,928	7,203	8,529	7,276	5,666

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

Semi Annual  
1/2

Quarterly  
1/4

Monthly  
1/12

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

**MANHATTANLIFE INSURANCE AND ANNUITY COMPANY**  
**ANNUAL PREFERRED ATTAINED AGE PREMIUMS**  
**FOR USE IN MICHIGAN ZIP CODES**  
**480-485**

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,933	2,513	1,952	1,448	2,223	2,890	2,245	1,665
66	1,933	2,513	1,952	1,448	2,223	2,890	2,245	1,665
67	1,933	2,513	1,952	1,448	2,223	2,890	2,245	1,665
68	1,937	2,560	1,957	1,488	2,229	2,943	2,252	1,711
69	2,003	2,644	2,022	1,533	2,301	3,041	2,325	1,763
70	2,069	2,729	2,091	1,580	2,379	3,141	2,402	1,816
71	2,139	2,819	2,160	1,647	2,459	3,241	2,483	1,893
72	2,211	2,905	2,233	1,712	2,544	3,341	2,568	1,971
73	2,285	2,992	2,308	1,779	2,627	3,442	2,655	2,046
74	2,370	3,111	2,394	1,854	2,726	3,577	2,754	2,131
75	2,468	3,249	2,493	1,940	2,838	3,734	2,868	2,231
76	2,558	3,375	2,584	2,013	2,942	3,882	2,973	2,314
77	2,663	3,511	2,691	2,084	3,064	4,038	3,094	2,397
78	2,780	3,655	2,808	2,160	3,197	4,203	3,229	2,483
79	2,910	3,810	2,938	2,236	3,345	4,383	3,380	2,570
80	3,051	3,974	3,083	2,324	3,509	4,571	3,544	2,671
81	3,207	4,149	3,240	2,448	3,688	4,770	3,725	2,815
82	3,379	4,333	3,411	2,583	3,884	4,981	3,924	2,972
83	3,562	4,529	3,597	2,731	4,094	5,206	4,137	3,140
84	3,763	4,735	3,800	2,890	4,326	5,444	4,370	3,324
85	3,980	4,955	4,020	3,065	4,576	5,699	4,624	3,524
86	4,191	5,167	4,232	3,234	4,819	5,942	4,867	3,720
87	4,410	5,392	4,454	3,413	5,074	6,201	5,123	3,925
88	4,632	5,630	4,679	3,593	5,328	6,477	5,381	4,134
89	4,858	5,887	4,905	3,777	5,584	6,770	5,643	4,344
90	5,080	6,130	5,131	3,959	5,842	7,047	5,902	4,554
91	5,290	6,354	5,344	4,132	6,084	7,307	6,146	4,751
92	5,497	6,587	5,553	4,302	6,323	7,574	6,386	4,947
93	5,703	6,801	5,760	4,470	6,557	7,820	6,623	5,142
94	5,902	7,014	5,962	4,636	6,790	8,067	6,856	5,330
95	6,097	7,227	6,159	4,796	7,012	8,312	7,083	5,515
96	6,230	7,380	6,294	4,901	7,166	8,485	7,240	5,636
97	6,355	7,528	6,419	5,000	7,309	8,655	7,383	5,750
98	6,477	7,669	6,541	5,095	7,447	8,819	7,523	5,858
99	6,593	7,807	6,659	5,187	7,582	8,978	7,659	5,965

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

Semi Annual  
1/2

Quarterly  
1/4

Monthly  
1/12

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

**MANHATTANLIFE INSURANCE AND ANNUITY COMPANY**  
**ANNUAL STANDARD ATTAINED AGE PREMIUMS**  
**FOR USE IN MICHIGAN ZIP CODES**  
**480-485**

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	2,223	2,890	2,245	1,665	2,556	3,325	2,581	1,916
66	2,223	2,890	2,245	1,665	2,556	3,325	2,581	1,916
67	2,223	2,890	2,245	1,665	2,556	3,325	2,581	1,916
68	2,229	2,943	2,252	1,711	2,562	3,384	2,590	1,968
69	2,301	3,041	2,325	1,763	2,645	3,498	2,674	2,027
70	2,379	3,141	2,402	1,816	2,736	3,611	2,762	2,091
71	2,459	3,241	2,483	1,893	2,829	3,726	2,855	2,177
72	2,544	3,341	2,568	1,971	2,927	3,843	2,954	2,264
73	2,627	3,442	2,655	2,046	3,023	3,958	3,052	2,353
74	2,726	3,577	2,754	2,131	3,135	4,114	3,166	2,452
75	2,838	3,734	2,868	2,231	3,266	4,295	3,298	2,566
76	2,942	3,882	2,973	2,314	3,383	4,465	3,418	2,661
77	3,064	4,038	3,094	2,397	3,522	4,644	3,559	2,758
78	3,197	4,203	3,229	2,483	3,678	4,833	3,713	2,855
79	3,345	4,383	3,380	2,570	3,846	5,039	3,885	2,954
80	3,509	4,571	3,544	2,671	4,035	5,258	4,077	3,073
81	3,688	4,770	3,725	2,815	4,241	5,487	4,285	3,238
82	3,884	4,981	3,924	2,972	4,467	5,728	4,511	3,417
83	4,094	5,206	4,137	3,140	4,710	5,987	4,758	3,611
84	4,326	5,444	4,370	3,324	4,976	6,262	5,026	3,823
85	4,576	5,699	4,624	3,524	5,262	6,553	5,315	4,053
86	4,819	5,942	4,867	3,720	5,540	6,833	5,598	4,278
87	5,074	6,201	5,123	3,925	5,832	7,131	5,891	4,514
88	5,328	6,477	5,381	4,134	6,126	7,447	6,189	4,752
89	5,584	6,770	5,643	4,344	6,422	7,784	6,486	4,994
90	5,842	7,047	5,902	4,554	6,719	8,106	6,787	5,237
91	6,084	7,307	6,146	4,751	6,997	8,403	7,067	5,465
92	6,323	7,574	6,386	4,947	7,270	8,711	7,344	5,689
93	6,557	7,820	6,623	5,142	7,542	8,994	7,618	5,912
94	6,790	8,067	6,856	5,330	7,805	9,277	7,884	6,131
95	7,012	8,312	7,083	5,515	8,064	9,558	8,145	6,343
96	7,166	8,485	7,240	5,636	8,242	9,758	8,325	6,484
97	7,309	8,655	7,383	5,750	8,405	9,953	8,490	6,613
98	7,447	8,819	7,523	5,858	8,565	10,144	8,651	6,738
99	7,582	8,978	7,659	5,965	8,719	10,325	8,808	6,859

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

**Semi Annual**  
1/2

**Quarterly**  
1/4

**Monthly**  
1/12

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

### **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 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 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day  All but \$816 a day  \$0  \$0	\$0 \$408 a day  \$816 a day  100% of Medicare eligible expenses  \$0	\$1632 (Part A deductible) \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$204 a day \$0	\$0 \$0 \$0	\$0 Up to \$204 a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES –</b> 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* Remainder of Medicare Approved Amounts	        \$0  Generally 80%	        \$0  Generally 20%	        \$240 (Part B deductible)  \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  \$0  80%	All costs  \$0  20%	\$0  \$240 (Part B deductible)  \$0
<b>CLINICAL LABORATORY            SERVICES – TESTS FOR            DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

## PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> 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

## 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day  All but \$816 a day  \$0  \$0	\$1632 (Part A deductible) \$408 a day  \$816 a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES –</b> 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* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$240 (Part B deductible)  Generally 20%	\$0  \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$240 of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 \$0 80%	All costs \$240 (Part B deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> 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 \$240 (Part B deductible) 20%	\$0 \$0 \$0

**OTHER SERVICES – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> 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

**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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day  All but \$816 a day  \$0  \$0	\$1632 (Part A deductible) \$408 a day  \$816 a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES –</b> 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* Remainder of Medicare Approved Amounts	       \$0  Generally 80%	       \$0  Generally 20%	       \$240 (Part B deductible)  \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	0%
<b>BLOOD</b> First 3 pints Next \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  \$0  80%	All costs  \$0  20%	\$0  \$240 (Part B deductible)  \$0
<b>CLINICAL LABORATORY            SERVICES – TESTS FOR            DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> 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
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> 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

## 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day  All but \$816 a day  \$0  \$0	\$1632 (Part A deductible) \$408 a day  \$816 a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES –</b> 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* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  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.	\$240 (Part B deductible)  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.
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$240 (Part B deductible) \$0
<b>CLINICAL LABORATORY            SERVICES – TESTS FOR            DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PLAN N**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> 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
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> 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.