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.

These charts show the benefits included in each of the standard Medicare supplement plans. Every Company must make Plan "A" and either Plan C or F available for those eligible for Medicare prior to January 1, 2020 and either Plan D or G available for those eligible for Medicare on or after January 1, 2020. Some plans may not be available in your state. 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 ATTAINED AGE PREMIUMS
FOR USE IN KENTUCKY ZIP CODES
402, 410, 416-418

Attained Age	Female				Male			
	MCMSAAKY	MCMSAFKY	MCMSAGKY	MCMSANKY	MCMSAAKY	MCMSAFKY	MCMSAGKY	MCMSANKY
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	1,833	2,194	1,716	1,280	2,107	2,524	1,974	1,472
65	1,690	2,019	1,593	1,166	1,941	2,323	1,835	1,341
66	1,690	2,019	1,593	1,166	1,941	2,323	1,835	1,341
67	1,690	2,019	1,593	1,166	1,941	2,323	1,835	1,341
68	1,725	2,056	1,597	1,197	1,984	2,365	1,838	1,378
69	1,785	2,126	1,649	1,234	2,052	2,443	1,896	1,418
70	1,848	2,193	1,680	1,272	2,125	2,524	1,931	1,461
71	1,902	2,266	1,736	1,326	2,189	2,605	1,995	1,523
72	1,958	2,334	1,795	1,379	2,253	2,684	2,065	1,586
73	2,014	2,405	1,864	1,432	2,316	2,766	2,143	1,646
74	2,089	2,500	1,937	1,493	2,404	2,874	2,229	1,716
75	2,178	2,609	2,019	1,561	2,504	3,000	2,321	1,795
76	2,251	2,712	2,092	1,619	2,589	3,118	2,405	1,863
77	2,328	2,822	2,178	1,678	2,677	3,245	2,503	1,930
78	2,411	2,936	2,272	1,738	2,771	3,378	2,614	1,998
79	2,498	3,061	2,377	1,799	2,873	3,521	2,735	2,068
80	2,594	3,193	2,494	1,870	2,981	3,672	2,868	2,151
81	2,682	3,333	2,622	1,971	3,086	3,832	3,015	2,266
82	2,779	3,480	2,760	2,080	3,196	4,002	3,174	2,392
83	2,880	3,638	2,911	2,198	3,312	4,184	3,348	2,527
84	2,989	3,803	3,075	2,327	3,437	4,375	3,537	2,675
85	3,103	3,982	3,254	2,467	3,570	4,578	3,741	2,836
86	3,213	4,152	3,424	2,603	3,696	4,774	3,940	2,993
87	3,330	4,333	3,604	2,747	3,831	4,981	4,145	3,160
88	3,455	4,524	3,788	2,893	3,972	5,204	4,355	3,328
89	3,587	4,728	3,969	3,040	4,123	5,439	4,565	3,496
90	3,708	4,925	4,152	3,187	4,265	5,662	4,776	3,665
91	3,816	5,104	4,324	3,326	4,388	5,872	4,974	3,824
92	3,927	5,292	4,493	3,462	4,517	6,086	5,169	3,982
93	4,026	5,464	4,661	3,598	4,630	6,283	5,360	4,139
94	4,120	5,635	4,826	3,731	4,739	6,482	5,549	4,289
95	4,216	5,807	4,984	3,860	4,849	6,678	5,731	4,439
96	4,305	5,929	5,093	3,945	4,950	6,817	5,856	4,536
97	4,391	6,048	5,195	4,025	5,050	6,954	5,974	4,629
98	4,475	6,161	5,293	4,100	5,147	7,085	6,089	4,715
99	4,555	6,273	5,389	4,175	5,238	7,213	6,198	4,801

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

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

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

MANHATTANLIFE INSURANCE AND ANNUITY COMPANY
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN KENTUCKY ZIP CODES
402, 410, 416-418

Attained Age	Female				Male			
	MCMSAAKY	MCMSAFKY	MCMSAGKY	MCMSANKY	MCMSAAKY	MCMSAFKY	MCMSAGKY	MCMSANKY
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	2,107	2,524	1,974	1,472	2,423	2,902	2,270	1,693
65	1,941	2,323	1,835	1,341	2,232	2,670	2,109	1,544
66	1,941	2,323	1,835	1,341	2,232	2,670	2,109	1,544
67	1,941	2,323	1,835	1,341	2,232	2,670	2,109	1,544
68	1,984	2,365	1,838	1,378	2,281	2,720	2,112	1,584
69	2,052	2,443	1,896	1,418	2,361	2,810	2,181	1,631
70	2,125	2,524	1,931	1,461	2,444	2,902	2,221	1,682
71	2,189	2,605	1,995	1,523	2,518	2,993	2,295	1,751
72	2,253	2,684	2,065	1,586	2,591	3,087	2,375	1,823
73	2,316	2,766	2,143	1,646	2,664	3,180	2,464	1,893
74	2,404	2,874	2,229	1,716	2,763	3,306	2,562	1,974
75	2,504	3,000	2,321	1,795	2,879	3,450	2,670	2,065
76	2,589	3,118	2,405	1,863	2,976	3,586	2,765	2,142
77	2,677	3,245	2,503	1,930	3,079	3,729	2,879	2,220
78	2,771	3,378	2,614	1,998	3,187	3,884	3,006	2,299
79	2,873	3,521	2,735	2,068	3,304	4,048	3,144	2,378
80	2,981	3,672	2,868	2,151	3,429	4,224	3,299	2,474
81	3,086	3,832	3,015	2,266	3,549	4,408	3,467	2,606
82	3,196	4,002	3,174	2,392	3,676	4,603	3,651	2,750
83	3,312	4,184	3,348	2,527	3,810	4,810	3,849	2,907
84	3,437	4,375	3,537	2,675	3,953	5,031	4,067	3,077
85	3,570	4,578	3,741	2,836	4,106	5,265	4,301	3,260
86	3,696	4,774	3,940	2,993	4,250	5,490	4,530	3,443
87	3,831	4,981	4,145	3,160	4,405	5,730	4,768	3,633
88	3,972	5,204	4,355	3,328	4,568	5,985	5,009	3,825
89	4,123	5,439	4,565	3,496	4,743	6,253	5,250	4,019
90	4,265	5,662	4,776	3,665	4,905	6,513	5,492	4,216
91	4,388	5,872	4,974	3,824	5,048	6,751	5,718	4,397
92	4,517	6,086	5,169	3,982	5,194	6,997	5,945	4,580
93	4,630	6,283	5,360	4,139	5,323	7,226	6,165	4,758
94	4,739	6,482	5,549	4,289	5,452	7,453	6,379	4,933
95	4,849	6,678	5,731	4,439	5,576	7,679	6,591	5,106
96	4,950	6,817	5,856	4,536	5,693	7,841	6,736	5,218
97	5,050	6,954	5,974	4,629	5,807	7,997	6,870	5,322
98	5,147	7,085	6,089	4,715	5,917	8,150	7,001	5,422
99	5,238	7,213	6,198	4,801	6,025	8,296	7,127	5,519

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.

MANHATTANLIFE INSURANCE AND ANNUITY COMPANY
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN KENTUCKY ZIP CODES
400, 403-409, 411-414, 419-428, 401, 415

Attained Age	Female				Male			
	MCMSAAKY	MCMSAFKY	MCMSAGKY	MCMSANKY	MCMSAAKY	MCMSAFKY	MCMSAGKY	MCMSANKY
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	1,683	2,015	1,576	1,175	1,935	2,318	1,813	1,352
65	1,552	1,854	1,463	1,071	1,783	2,133	1,685	1,231
66	1,552	1,854	1,463	1,071	1,783	2,133	1,685	1,231
67	1,552	1,854	1,463	1,071	1,783	2,133	1,685	1,231
68	1,584	1,888	1,467	1,099	1,822	2,172	1,688	1,265
69	1,639	1,952	1,515	1,133	1,885	2,244	1,742	1,302
70	1,697	2,014	1,543	1,168	1,951	2,318	1,773	1,342
71	1,747	2,081	1,594	1,218	2,011	2,392	1,832	1,399
72	1,798	2,144	1,649	1,266	2,069	2,465	1,896	1,456
73	1,850	2,209	1,712	1,315	2,127	2,540	1,968	1,512
74	1,919	2,296	1,779	1,371	2,208	2,640	2,047	1,576
75	2,000	2,396	1,854	1,434	2,300	2,755	2,131	1,649
76	2,067	2,490	1,922	1,487	2,378	2,864	2,209	1,711
77	2,138	2,592	2,000	1,541	2,459	2,980	2,299	1,772
78	2,214	2,696	2,086	1,596	2,545	3,102	2,400	1,835
79	2,294	2,811	2,183	1,652	2,639	3,234	2,512	1,899
80	2,382	2,932	2,291	1,717	2,738	3,372	2,634	1,976
81	2,463	3,061	2,408	1,810	2,834	3,519	2,769	2,081
82	2,552	3,196	2,534	1,910	2,935	3,676	2,915	2,197
83	2,645	3,341	2,673	2,019	3,042	3,842	3,074	2,321
84	2,745	3,493	2,824	2,137	3,156	4,018	3,248	2,457
85	2,849	3,657	2,988	2,265	3,279	4,204	3,435	2,605
86	2,951	3,813	3,145	2,390	3,394	4,384	3,618	2,749
87	3,058	3,979	3,310	2,523	3,518	4,575	3,807	2,902
88	3,173	4,154	3,479	2,657	3,648	4,779	4,000	3,056
89	3,294	4,342	3,645	2,792	3,786	4,995	4,192	3,210
90	3,406	4,523	3,813	2,927	3,917	5,200	4,386	3,366
91	3,505	4,687	3,971	3,055	4,030	5,393	4,568	3,512
92	3,606	4,860	4,127	3,180	4,148	5,589	4,747	3,657
93	3,697	5,018	4,280	3,304	4,252	5,770	4,922	3,801
94	3,784	5,175	4,432	3,426	4,352	5,953	5,096	3,939
95	3,872	5,333	4,577	3,545	4,453	6,133	5,263	4,077
96	3,954	5,445	4,677	3,623	4,546	6,260	5,378	4,166
97	4,033	5,554	4,771	3,696	4,638	6,386	5,486	4,251
98	4,109	5,658	4,861	3,766	4,727	6,507	5,592	4,330
99	4,183	5,761	4,949	3,834	4,811	6,624	5,692	4,409

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.

MANHATTANLIFE INSURANCE AND ANNUITY COMPANY
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN KENTUCKY ZIP CODES
400, 403-409, 411-414, 419-428, 401, 415

Attained	Female				Male			
	MCMSAAKY	MCMSAFKY	MCMSAGKY	MCMSANKY	MCMSAAKY	MCMSAFKY	MCMSAGKY	MCMSANKY
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	1,935	2,318	1,813	1,352	2,225	2,665	2,084	1,555
65	1,783	2,133	1,685	1,231	2,050	2,452	1,937	1,418
66	1,783	2,133	1,685	1,231	2,050	2,452	1,937	1,418
67	1,783	2,133	1,685	1,231	2,050	2,452	1,937	1,418
68	1,822	2,172	1,688	1,265	2,095	2,498	1,940	1,454
69	1,885	2,244	1,742	1,302	2,168	2,580	2,003	1,498
70	1,951	2,318	1,773	1,342	2,245	2,665	2,039	1,544
71	2,011	2,392	1,832	1,399	2,312	2,749	2,108	1,608
72	2,069	2,465	1,896	1,456	2,380	2,835	2,181	1,674
73	2,127	2,540	1,968	1,512	2,446	2,921	2,263	1,739
74	2,208	2,640	2,047	1,576	2,537	3,036	2,353	1,813
75	2,300	2,755	2,131	1,649	2,644	3,168	2,452	1,896
76	2,378	2,864	2,209	1,711	2,733	3,293	2,539	1,967
77	2,459	2,980	2,299	1,772	2,828	3,425	2,644	2,039
78	2,545	3,102	2,400	1,835	2,927	3,567	2,760	2,111
79	2,639	3,234	2,512	1,899	3,034	3,718	2,887	2,184
80	2,738	3,372	2,634	1,976	3,149	3,879	3,029	2,272
81	2,834	3,519	2,769	2,081	3,259	4,048	3,184	2,393
82	2,935	3,676	2,915	2,197	3,376	4,227	3,353	2,525
83	3,042	3,842	3,074	2,321	3,499	4,417	3,535	2,669
84	3,156	4,018	3,248	2,457	3,631	4,621	3,735	2,826
85	3,279	4,204	3,435	2,605	3,771	4,835	3,950	2,994
86	3,394	4,384	3,618	2,749	3,903	5,042	4,160	3,162
87	3,518	4,575	3,807	2,902	4,046	5,262	4,379	3,336
88	3,648	4,779	4,000	3,056	4,195	5,496	4,600	3,513
89	3,786	4,995	4,192	3,210	4,356	5,743	4,821	3,691
90	3,917	5,200	4,386	3,366	4,505	5,981	5,044	3,872
91	4,030	5,393	4,568	3,512	4,636	6,200	5,252	4,038
92	4,148	5,589	4,747	3,657	4,770	6,426	5,459	4,206
93	4,252	5,770	4,922	3,801	4,889	6,636	5,662	4,370
94	4,352	5,953	5,096	3,939	5,007	6,845	5,858	4,531
95	4,453	6,133	5,263	4,077	5,121	7,052	6,053	4,689
96	4,546	6,260	5,378	4,166	5,228	7,201	6,186	4,792
97	4,638	6,386	5,486	4,251	5,333	7,344	6,309	4,888
98	4,727	6,507	5,592	4,330	5,434	7,484	6,430	4,980
99	4,811	6,624	5,692	4,409	5,533	7,619	6,545	5,069

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.

PREMIUM INFORMATION

We, ManhattanLife Insurance and Annuity Company, can only raise your premium if We raise the premium for all policies like yours in Kentucky. 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.

Household Discount

Household Discount means a discount when (1) the applicant is married; or, (2) the applicant has resided for the last 12 months with someone that has an existing Medicare Supplement Policy. The discount will remain in effect for the life of the policy.

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 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 $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 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 $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 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 $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.