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 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.

NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.

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 Premium Rates
FOR USE IN CALIFORNIA ZIP CODES
932-939, 950-961

Attained Age	Male & Female Rates			
	Plan A	Plan F	Plan G	Plan N
0-64	4,143	5,018	4,164	3,310
65	1,770	2,192	1,778	1,380
66	1,770	2,192	1,778	1,380
67	1,770	2,192	1,778	1,380
68	1,844	2,277	1,854	1,438
69	1,925	2,376	1,935	1,495
70	2,008	2,479	2,019	1,560
71	2,089	2,579	2,100	1,625
72	2,172	2,681	2,182	1,691
73	2,257	2,794	2,269	1,759
74	2,353	2,915	2,366	1,831
75	2,461	3,052	2,474	1,908
76	2,554	3,179	2,565	1,980
77	2,652	3,317	2,666	2,061
78	2,761	3,460	2,773	2,149
79	2,877	3,606	2,891	2,247
80	3,003	3,758	3,018	2,358
81	3,157	3,914	3,173	2,485
82	3,320	4,084	3,337	2,623
83	3,495	4,277	3,513	2,769
84	3,677	4,481	3,695	2,922
85	3,867	4,698	3,888	3,083
86	4,050	4,909	4,070	3,233
87	4,237	5,127	4,259	3,388
88	4,434	5,355	4,456	3,554
89	4,640	5,594	4,663	3,732
90	4,853	5,840	4,877	3,912
91	5,063	6,085	5,089	4,086
92	5,282	6,331	5,310	4,263
93	5,511	6,574	5,539	4,437
94	5,749	6,809	5,777	4,606
95	5,996	7,029	6,026	4,765
96	6,200	7,175	6,231	4,866
97	6,386	7,319	6,418	4,964
98	6,507	7,458	6,540	5,057
99	6,624	7,594	6,658	5,149

Premium payable other than annual will be determined according to the following factors:
Semi Annual: 1/2 **Quarterly: 1/4** **Monthly: 1/12**
Spousal Discount Factor: .93
There is a one-time $25 policy fee

ManhattanLife Insurance and Annuity Company
Annual Standard Premium Rates
FOR USE IN CALIFORNIA ZIP CODES
932-939, 950-961

Attained Age	Male & Female Rates			
	Plan A	Plan F	Plan G	Plan N
0-64	4,765	5,771	4,788	3,807
65	2,036	2,519	2,046	1,587
66	2,036	2,519	2,046	1,587
67	2,036	2,519	2,046	1,587
68	2,121	2,619	2,133	1,655
69	2,214	2,734	2,225	1,720
70	2,310	2,850	2,323	1,795
71	2,403	2,965	2,414	1,870
72	2,498	3,082	2,510	1,945
73	2,596	3,212	2,609	2,024
74	2,707	3,353	2,720	2,105
75	2,830	3,510	2,844	2,194
76	2,936	3,657	2,952	2,278
77	3,050	3,814	3,066	2,369
78	3,175	3,978	3,190	2,471
79	3,308	4,148	3,325	2,583
80	3,453	4,323	3,470	2,712
81	3,629	4,502	3,648	2,859
82	3,819	4,697	3,837	3,016
83	4,019	4,917	4,039	3,184
84	4,228	5,154	4,250	3,360
85	4,449	5,403	4,471	3,545
86	4,656	5,644	4,679	3,717
87	4,873	5,898	4,897	3,896
88	5,100	6,158	5,124	4,087
89	5,335	6,432	5,362	4,290
90	5,581	6,716	5,609	4,499
91	5,823	6,997	5,851	4,700
92	6,075	7,281	6,106	4,902
93	6,338	7,563	6,370	5,102
94	6,611	7,829	6,644	5,297
95	6,896	8,083	6,930	5,481
96	7,130	8,254	7,166	5,596
97	7,344	8,418	7,381	5,708
98	7,483	8,578	7,521	5,817
99	7,618	8,731	7,655	5,921

Premium payable other than annual will be determined according to the following factors:
Semi Annual: 1/2 **Quarterly: 1/4** **Monthly: 1/12**
Spousal Discount Factor: .93
There is a one-time $25 policy fee

ManhattanLife Insurance and Annuity Company
Annual Preferred Premium Rates
FOR USE IN CALIFORNIA ZIP CODES
919-925, 930-931, 940-949

Attained Age	Male & Female Rates			
	Plan A	Plan F	Plan G	Plan N
0-64	4,623	5,599	4,646	3,693
65	1,975	2,445	1,984	1,540
66	1,975	2,445	1,984	1,540
67	1,975	2,445	1,984	1,540
68	2,057	2,541	2,069	1,605
69	2,148	2,651	2,159	1,668
70	2,241	2,766	2,253	1,741
71	2,331	2,878	2,343	1,814
72	2,423	2,991	2,435	1,887
73	2,519	3,117	2,531	1,963
74	2,626	3,252	2,639	2,043
75	2,746	3,406	2,760	2,128
76	2,849	3,547	2,862	2,209
77	2,960	3,702	2,974	2,299
78	3,080	3,861	3,094	2,398
79	3,210	4,024	3,226	2,507
80	3,351	4,193	3,368	2,631
81	3,522	4,367	3,540	2,773
82	3,705	4,557	3,724	2,927
83	3,900	4,772	3,920	3,090
84	4,103	5,000	4,122	3,261
85	4,315	5,242	4,339	3,440
86	4,519	5,477	4,541	3,607
87	4,728	5,721	4,752	3,780
88	4,947	5,975	4,971	3,965
89	5,177	6,241	5,202	4,164
90	5,414	6,516	5,442	4,365
91	5,649	6,789	5,678	4,559
92	5,894	7,064	5,924	4,756
93	6,149	7,335	6,180	4,951
94	6,415	7,597	6,446	5,139
95	6,691	7,843	6,724	5,317
96	6,918	8,006	6,953	5,429
97	7,125	8,166	7,161	5,539
98	7,260	8,322	7,297	5,642
99	7,391	8,474	7,428	5,745

Premium payable other than annual will be determined according to the following factors:
Semi Annual: 1/2 **Quarterly: 1/4** **Monthly: 1/12**
Spousal Discount Factor: .93
There is a one-time $25 policy fee

ManhattanLife Insurance and Annuity Company
Annual Standard Premium Rates
FOR USE IN CALIFORNIA ZIP CODES
919-925, 930-931, 940-949

Attained Age	Male & Female Rates			
	Plan A	Plan F	Plan G	Plan N
0-64	5,317	6,440	5,342	4,247
65	2,272	2,811	2,283	1,771
66	2,272	2,811	2,283	1,771
67	2,272	2,811	2,283	1,771
68	2,367	2,922	2,380	1,847
69	2,470	3,051	2,483	1,919
70	2,578	3,180	2,592	2,002
71	2,681	3,308	2,693	2,086
72	2,787	3,439	2,801	2,170
73	2,897	3,584	2,911	2,258
74	3,020	3,741	3,035	2,349
75	3,158	3,917	3,174	2,448
76	3,276	4,080	3,293	2,542
77	3,404	4,256	3,421	2,644
78	3,543	4,438	3,559	2,757
79	3,691	4,628	3,710	2,882
80	3,853	4,824	3,872	3,026
81	4,049	5,023	4,070	3,190
82	4,261	5,241	4,281	3,366
83	4,485	5,487	4,507	3,553
84	4,718	5,751	4,742	3,749
85	4,964	6,028	4,988	3,956
86	5,195	6,297	5,221	4,148
87	5,437	6,580	5,464	4,347
88	5,690	6,871	5,718	4,560
89	5,953	7,177	5,983	4,787
90	6,228	7,493	6,258	5,020
91	6,497	7,807	6,529	5,244
92	6,779	8,124	6,813	5,470
93	7,072	8,439	7,107	5,693
94	7,377	8,735	7,414	5,911
95	7,695	9,018	7,733	6,115
96	7,955	9,209	7,996	6,243
97	8,195	9,393	8,235	6,368
98	8,350	9,571	8,392	6,490
99	8,500	9,742	8,541	6,607

Premium payable other than annual will be determined according to the following factors:
Semi Annual: 1/12 **Quarterly: 1/4** **Monthly: 1/12**
Spousal Discount Factor: .93
There is a one-time $25 policy fee

ManhattanLife Insurance and Annuity Company
Annual Preferred Premium Rates
FOR USE IN CALIFORNIA ZIP CODES
900-918, 926-928

Attained Age	Male & Female Rates			
	Plan A	Plan F	Plan G	Plan N
0-64	5,495	6,655	5,523	4,390
65	2,347	2,907	2,359	1,831
66	2,347	2,907	2,359	1,831
67	2,347	2,907	2,359	1,831
68	2,446	3,020	2,460	1,908
69	2,553	3,151	2,567	1,983
70	2,664	3,287	2,678	2,069
71	2,771	3,421	2,785	2,156
72	2,880	3,556	2,894	2,243
73	2,994	3,706	3,009	2,334
74	3,121	3,866	3,137	2,428
75	3,265	4,048	3,281	2,530
76	3,387	4,216	3,402	2,626
77	3,518	4,400	3,536	2,733
78	3,662	4,589	3,678	2,850
79	3,815	4,783	3,834	2,980
80	3,983	4,985	4,003	3,127
81	4,187	5,191	4,208	3,296
82	4,404	5,417	4,426	3,479
83	4,636	5,673	4,659	3,673
84	4,877	5,943	4,900	3,876
85	5,129	6,231	5,157	4,089
86	5,371	6,510	5,398	4,288
87	5,620	6,800	5,649	4,493
88	5,880	7,103	5,909	4,714
89	6,154	7,419	6,184	4,949
90	6,436	7,745	6,469	5,189
91	6,715	8,070	6,750	5,419
92	7,006	8,397	7,042	5,654
93	7,309	8,719	7,346	5,885
94	7,626	9,030	7,662	6,108
95	7,953	9,323	7,992	6,320
96	8,223	9,517	8,264	6,454
97	8,470	9,707	8,513	6,584
98	8,630	9,892	8,674	6,707
99	8,786	10,072	8,830	6,829

Premium payable other than annual will be determined according to the following factors:
Semi Annual: 1/4 **Quarterly: 1/4** **Monthly: 1/12**
Spousal Discount Factor: .93
There is a one-time $25 policy fee

ManhattanLife Insurance and Annuity Company
Annual Standard Premium Rates
FOR USE IN CALIFORNIA ZIP CODES
900-918, 926-928

Attained Age	Male & Female Rates			
	Plan A	Plan F	Plan G	Plan N
0-64	6,320	7,655	6,350	5,049
65	2,700	3,342	2,714	2,105
66	2,700	3,342	2,714	2,105
67	2,700	3,342	2,714	2,105
68	2,814	3,474	2,829	2,195
69	2,936	3,626	2,951	2,281
70	3,064	3,780	3,081	2,380
71	3,187	3,932	3,202	2,480
72	3,313	4,087	3,329	2,579
73	3,444	4,260	3,460	2,684
74	3,590	4,447	3,607	2,792
75	3,754	4,656	3,772	2,909
76	3,895	4,850	3,915	3,021
77	4,046	5,059	4,066	3,142
78	4,211	5,276	4,231	3,277
79	4,387	5,501	4,410	3,426
80	4,580	5,734	4,603	3,597
81	4,813	5,971	4,838	3,791
82	5,065	6,229	5,089	4,001
83	5,331	6,522	5,358	4,224
84	5,608	6,836	5,637	4,457
85	5,901	7,166	5,930	4,702
86	6,175	7,486	6,206	4,930
87	6,463	7,822	6,495	5,167
88	6,764	8,167	6,796	5,421
89	7,076	8,531	7,111	5,690
90	7,403	8,907	7,439	5,967
91	7,723	9,280	7,760	6,233
92	8,058	9,657	8,098	6,502
93	8,407	10,031	8,448	6,767
94	8,768	10,384	8,812	7,026
95	9,146	10,720	9,192	7,269
96	9,456	10,947	9,504	7,421
97	9,741	11,165	9,789	7,570
98	9,925	11,377	9,975	7,715
99	10,104	11,581	10,153	7,854

Premium payable other than annual will be determined according to the following factors:
Semi Annual: 1/2 **Quarterly: 1/4** **Monthly: 1/12**
Spousal Discount Factor: .93
There is a one-time $25 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 77292-4408. 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 contain a pre-existing condition limitation, and this policy does not pay benefits for (a) Expenses incurred while this policy is not in force except as provided in the Extension of Benefits section; (b) That portion of any expense incurred which is paid for by Medicare; (c) Services for non-Medicare Eligible Expenses unless specifically covered in the policy; or (d) Services for which a charge is not normally made in the absence of insurance.

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 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 $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.