

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.

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 INDIANA ZIP CODES
463-464

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	11,223	N/A	N/A	N/A	12,906	N/A	N/A	N/A
65	2,041	2,299	1,881	1,370	2,346	2,644	2,164	1,574
66	2,041	2,299	1,881	1,370	2,346	2,644	2,164	1,574
67	2,041	2,299	1,881	1,370	2,346	2,644	2,164	1,574
68	2,084	2,341	1,886	1,406	2,397	2,692	2,170	1,618
69	2,157	2,418	1,947	1,448	2,481	2,781	2,240	1,666
70	2,233	2,497	2,015	1,494	2,568	2,873	2,314	1,717
71	2,299	2,578	2,079	1,557	2,646	2,965	2,393	1,788
72	2,367	2,658	2,153	1,619	2,722	3,057	2,475	1,862
73	2,435	2,739	2,225	1,681	2,799	3,149	2,558	1,933
74	2,525	2,845	2,307	1,753	2,905	3,272	2,654	2,015
75	2,631	2,970	2,401	1,832	3,026	3,416	2,762	2,108
76	2,720	3,087	2,491	1,900	3,129	3,551	2,865	2,186
77	2,813	3,213	2,592	1,970	3,235	3,694	2,981	2,266
78	2,913	3,343	2,705	2,040	3,349	3,844	3,111	2,345
79	3,020	3,486	2,830	2,111	3,473	4,008	3,256	2,428
80	3,134	3,635	2,970	2,197	3,603	4,183	3,416	2,525
81	3,243	3,795	3,121	2,313	3,731	4,363	3,589	2,660
82	3,358	3,962	3,286	2,440	3,862	4,556	3,780	2,808
83	3,481	4,141	3,466	2,582	4,003	4,763	3,987	2,967
84	3,612	4,331	3,662	2,730	4,154	4,981	4,209	3,141
85	3,750	4,532	3,873	2,895	4,315	5,212	4,454	3,328
86	3,885	4,728	4,079	3,057	4,467	5,435	4,690	3,514
87	4,025	4,932	4,292	3,223	4,629	5,671	4,936	3,709
88	4,175	5,150	4,509	3,395	4,801	5,924	5,185	3,905
89	4,336	5,384	4,725	3,570	4,983	6,193	5,436	4,103
90	4,483	5,607	4,944	3,741	5,155	6,447	5,687	4,302
91	4,613	5,811	5,149	3,904	5,304	6,684	5,921	4,488
92	4,747	6,025	5,350	4,064	5,459	6,930	6,153	4,675
93	4,865	6,222	5,548	4,223	5,596	7,154	6,381	4,856
94	4,981	6,416	5,743	4,379	5,727	7,377	6,604	5,035
95	5,096	6,611	5,934	4,531	5,860	7,603	6,823	5,211
96	5,204	6,751	6,063	4,631	5,983	7,763	6,975	5,326
97	5,307	6,885	6,185	4,724	6,103	7,917	7,114	5,433
98	5,407	7,016	6,303	4,813	6,220	8,068	7,247	5,536
99	5,505	7,144	6,417	4,900	6,331	8,213	7,380	5,635

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 applicants.

ManhattanLife Insurance and Annuity Company
Annual Standard Premium Rates
FOR USE IN INDIANA ZIP CODES
463-464

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	12,906	N/A	N/A	N/A	14,843	N/A	N/A	N/A
65	2,346	2,644	2,164	1,574	2,699	3,039	2,489	1,811
66	2,346	2,644	2,164	1,574	2,699	3,039	2,489	1,811
67	2,346	2,644	2,164	1,574	2,699	3,039	2,489	1,811
68	2,397	2,692	2,170	1,618	2,758	3,097	2,494	1,858
69	2,481	2,781	2,240	1,666	2,853	3,199	2,577	1,915
70	2,568	2,873	2,314	1,717	2,954	3,303	2,662	1,975
71	2,646	2,965	2,393	1,788	3,042	3,410	2,752	2,057
72	2,722	3,057	2,475	1,862	3,131	3,514	2,845	2,140
73	2,799	3,149	2,558	1,933	3,219	3,620	2,942	2,222
74	2,905	3,272	2,654	2,015	3,340	3,764	3,050	2,317
75	3,026	3,416	2,762	2,108	3,480	3,930	3,177	2,424
76	3,129	3,551	2,865	2,186	3,597	4,084	3,295	2,515
77	3,235	3,694	2,981	2,266	3,720	4,247	3,428	2,605
78	3,349	3,844	3,111	2,345	3,853	4,423	3,579	2,697
79	3,473	4,008	3,256	2,428	3,993	4,609	3,744	2,792
80	3,603	4,183	3,416	2,525	4,145	4,809	3,927	2,903
81	3,731	4,363	3,589	2,660	4,290	5,020	4,127	3,060
82	3,862	4,556	3,780	2,808	4,442	5,239	4,347	3,228
83	4,003	4,763	3,987	2,967	4,605	5,476	4,583	3,412
84	4,154	4,981	4,209	3,141	4,778	5,728	4,843	3,611
85	4,315	5,212	4,454	3,328	4,962	5,994	5,122	3,830
86	4,467	5,435	4,690	3,514	5,136	6,250	5,392	4,041
87	4,629	5,671	4,936	3,709	5,323	6,523	5,676	4,264
88	4,801	5,924	5,185	3,905	5,521	6,814	5,964	4,490
89	4,983	6,193	5,436	4,103	5,733	7,122	6,251	4,717
90	5,155	6,447	5,687	4,302	5,929	7,415	6,540	4,950
91	5,304	6,684	5,921	4,488	6,101	7,687	6,810	5,162
92	5,459	6,930	6,153	4,675	6,277	7,968	7,076	5,375
93	5,596	7,154	6,381	4,856	6,434	8,226	7,339	5,587
94	5,727	7,377	6,604	5,035	6,588	8,486	7,596	5,791
95	5,860	7,603	6,823	5,211	6,739	8,742	7,846	5,993
96	5,983	7,763	6,975	5,326	6,880	8,926	8,019	6,124
97	6,103	7,917	7,114	5,433	7,018	9,105	8,180	6,247
98	6,220	8,068	7,247	5,536	7,151	9,279	8,336	6,366
99	6,331	8,213	7,380	5,635	7,282	9,446	8,486	6,480

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 applicants.

ManhattanLife Insurance and Annuity Company
Annual Preferred Premium Rates
FOR USE IN INDIANA ZIP CODES
462

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	9,661	N/A	N/A	N/A	11,111	N/A	N/A	N/A
65	1,757	1,979	1,620	1,179	2,020	2,276	1,863	1,355
66	1,757	1,979	1,620	1,179	2,020	2,276	1,863	1,355
67	1,757	1,979	1,620	1,179	2,020	2,276	1,863	1,355
68	1,794	2,016	1,624	1,211	2,063	2,318	1,868	1,393
69	1,857	2,082	1,676	1,246	2,135	2,394	1,929	1,435
70	1,923	2,149	1,734	1,286	2,211	2,473	1,992	1,478
71	1,979	2,220	1,790	1,340	2,278	2,552	2,060	1,539
72	2,037	2,288	1,853	1,394	2,343	2,631	2,130	1,603
73	2,096	2,358	1,916	1,447	2,410	2,711	2,202	1,664
74	2,174	2,449	1,986	1,509	2,501	2,817	2,285	1,734
75	2,265	2,557	2,067	1,577	2,605	2,940	2,378	1,815
76	2,341	2,657	2,144	1,635	2,694	3,057	2,466	1,882
77	2,422	2,766	2,231	1,696	2,785	3,180	2,566	1,950
78	2,508	2,878	2,328	1,756	2,883	3,310	2,678	2,019
79	2,600	3,001	2,436	1,818	2,990	3,450	2,803	2,090
80	2,698	3,129	2,557	1,891	3,102	3,601	2,940	2,174
81	2,792	3,267	2,687	1,991	3,212	3,756	3,090	2,290
82	2,891	3,411	2,828	2,101	3,324	3,922	3,254	2,418
83	2,997	3,565	2,984	2,223	3,446	4,101	3,432	2,554
84	3,110	3,728	3,152	2,350	3,576	4,288	3,623	2,704
85	3,228	3,902	3,334	2,492	3,714	4,487	3,834	2,865
86	3,344	4,070	3,512	2,631	3,845	4,679	4,037	3,025
87	3,465	4,246	3,695	2,775	3,985	4,882	4,249	3,193
88	3,594	4,433	3,882	2,922	4,133	5,099	4,464	3,362
89	3,732	4,635	4,068	3,073	4,290	5,331	4,680	3,532
90	3,859	4,827	4,256	3,220	4,438	5,550	4,896	3,704
91	3,971	5,002	4,432	3,361	4,566	5,754	5,098	3,864
92	4,087	5,187	4,605	3,499	4,700	5,966	5,297	4,024
93	4,188	5,356	4,776	3,635	4,817	6,159	5,494	4,181
94	4,288	5,523	4,944	3,770	4,930	6,351	5,686	4,334
95	4,387	5,692	5,108	3,901	5,045	6,545	5,874	4,486
96	4,480	5,811	5,219	3,987	5,151	6,683	6,004	4,585
97	4,569	5,927	5,324	4,067	5,254	6,815	6,124	4,677
98	4,655	6,040	5,426	4,143	5,355	6,946	6,239	4,766
99	4,739	6,150	5,524	4,218	5,450	7,071	6,353	4,851

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 applicants.

ManhattanLife Insurance and Annuity Company
Annual Standard Premium Rates
FOR USE IN INDIANA ZIP CODES
462

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	11,111	N/A	N/A	N/A	12,778	N/A	N/A	N/A
65	2,020	2,276	1,863	1,355	2,324	2,617	2,142	1,559
66	2,020	2,276	1,863	1,355	2,324	2,617	2,142	1,559
67	2,020	2,276	1,863	1,355	2,324	2,617	2,142	1,559
68	2,063	2,318	1,868	1,393	2,374	2,666	2,147	1,600
69	2,135	2,394	1,929	1,435	2,456	2,754	2,219	1,648
70	2,211	2,473	1,992	1,478	2,543	2,843	2,292	1,700
71	2,278	2,552	2,060	1,539	2,619	2,935	2,369	1,771
72	2,343	2,631	2,130	1,603	2,696	3,025	2,449	1,842
73	2,410	2,711	2,202	1,664	2,771	3,117	2,532	1,913
74	2,501	2,817	2,285	1,734	2,875	3,240	2,625	1,995
75	2,605	2,940	2,378	1,815	2,996	3,383	2,735	2,087
76	2,694	3,057	2,466	1,882	3,097	3,515	2,836	2,165
77	2,785	3,180	2,566	1,950	3,203	3,656	2,951	2,242
78	2,883	3,310	2,678	2,019	3,317	3,808	3,081	2,322
79	2,990	3,450	2,803	2,090	3,437	3,968	3,223	2,404
80	3,102	3,601	2,940	2,174	3,568	4,140	3,381	2,499
81	3,212	3,756	3,090	2,290	3,693	4,321	3,553	2,634
82	3,324	3,922	3,254	2,418	3,824	4,510	3,742	2,779
83	3,446	4,101	3,432	2,554	3,964	4,714	3,945	2,937
84	3,576	4,288	3,623	2,704	4,113	4,931	4,169	3,109
85	3,714	4,487	3,834	2,865	4,272	5,160	4,409	3,297
86	3,845	4,679	4,037	3,025	4,421	5,381	4,642	3,479
87	3,985	4,882	4,249	3,193	4,583	5,615	4,887	3,671
88	4,133	5,099	4,464	3,362	4,753	5,866	5,134	3,865
89	4,290	5,331	4,680	3,532	4,935	6,131	5,382	4,061
90	4,438	5,550	4,896	3,704	5,104	6,384	5,630	4,261
91	4,566	5,754	5,098	3,864	5,252	6,617	5,863	4,444
92	4,700	5,966	5,297	4,024	5,403	6,860	6,091	4,627
93	4,817	6,159	5,494	4,181	5,539	7,081	6,318	4,809
94	4,930	6,351	5,686	4,334	5,672	7,305	6,539	4,986
95	5,045	6,545	5,874	4,486	5,801	7,526	6,755	5,159
96	5,151	6,683	6,004	4,585	5,923	7,684	6,903	5,272
97	5,254	6,815	6,124	4,677	6,042	7,838	7,042	5,378
98	5,355	6,946	6,239	4,766	6,156	7,988	7,177	5,481
99	5,450	7,071	6,353	4,851	6,269	8,132	7,305	5,579

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 applicants.

ManhattanLife Insurance and Annuity Company
Annual Preferred Premium Rates
FOR USE IN INDIANA ZIP CODES ALL EXCEPT
462-464

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	8,588	N/A	N/A	N/A	9,876	N/A	N/A	N/A
65	1,562	1,759	1,440	1,048	1,795	2,023	1,656	1,205
66	1,562	1,759	1,440	1,048	1,795	2,023	1,656	1,205
67	1,562	1,759	1,440	1,048	1,795	2,023	1,656	1,205
68	1,595	1,792	1,443	1,076	1,834	2,060	1,661	1,238
69	1,651	1,851	1,490	1,108	1,898	2,128	1,714	1,275
70	1,709	1,910	1,542	1,143	1,965	2,198	1,771	1,314
71	1,759	1,973	1,591	1,192	2,025	2,269	1,831	1,368
72	1,811	2,034	1,647	1,239	2,083	2,339	1,894	1,425
73	1,863	2,096	1,703	1,287	2,142	2,409	1,957	1,479
74	1,932	2,177	1,765	1,341	2,223	2,504	2,031	1,542
75	2,013	2,273	1,837	1,402	2,315	2,614	2,114	1,613
76	2,081	2,362	1,906	1,454	2,394	2,717	2,192	1,673
77	2,152	2,459	1,984	1,507	2,475	2,827	2,281	1,734
78	2,229	2,558	2,070	1,561	2,563	2,942	2,380	1,794
79	2,311	2,667	2,166	1,616	2,658	3,067	2,491	1,858
80	2,398	2,782	2,273	1,681	2,757	3,201	2,614	1,932
81	2,482	2,904	2,388	1,770	2,855	3,339	2,746	2,035
82	2,570	3,032	2,514	1,867	2,955	3,487	2,893	2,149
83	2,664	3,169	2,652	1,976	3,063	3,645	3,051	2,270
84	2,764	3,314	2,802	2,089	3,179	3,811	3,221	2,403
85	2,870	3,468	2,964	2,215	3,302	3,988	3,408	2,547
86	2,973	3,618	3,121	2,339	3,418	4,159	3,589	2,689
87	3,080	3,774	3,284	2,467	3,542	4,339	3,777	2,838
88	3,194	3,941	3,450	2,598	3,674	4,533	3,968	2,988
89	3,318	4,120	3,616	2,732	3,813	4,739	4,160	3,140
90	3,430	4,291	3,783	2,863	3,945	4,933	4,352	3,292
91	3,530	4,447	3,940	2,988	4,059	5,115	4,531	3,435
92	3,633	4,610	4,094	3,110	4,177	5,303	4,708	3,577
93	3,722	4,761	4,245	3,231	4,282	5,474	4,883	3,716
94	3,811	4,910	4,395	3,351	4,382	5,645	5,054	3,853
95	3,899	5,059	4,541	3,467	4,484	5,818	5,221	3,987
96	3,982	5,166	4,639	3,544	4,579	5,940	5,337	4,075
97	4,061	5,269	4,733	3,615	4,670	6,058	5,444	4,157
98	4,138	5,369	4,823	3,683	4,760	6,174	5,546	4,236
99	4,213	5,467	4,910	3,750	4,844	6,285	5,647	4,312

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 applicants.

ManhattanLife Insurance and Annuity Company
Annual Standard Premium Rates
FOR USE IN INDIANA ZIP CODES ALL EXCEPT
462-464

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	9,876	N/A	N/A	N/A	11,358	N/A	N/A	N/A
65	1,795	2,023	1,656	1,205	2,065	2,326	1,904	1,386
66	1,795	2,023	1,656	1,205	2,065	2,326	1,904	1,386
67	1,795	2,023	1,656	1,205	2,065	2,326	1,904	1,386
68	1,834	2,060	1,661	1,238	2,110	2,370	1,909	1,422
69	1,898	2,128	1,714	1,275	2,183	2,448	1,972	1,465
70	1,965	2,198	1,771	1,314	2,261	2,527	2,037	1,511
71	2,025	2,269	1,831	1,368	2,328	2,609	2,106	1,574
72	2,083	2,339	1,894	1,425	2,396	2,689	2,177	1,638
73	2,142	2,409	1,957	1,479	2,463	2,770	2,251	1,700
74	2,223	2,504	2,031	1,542	2,556	2,880	2,334	1,773
75	2,315	2,614	2,114	1,613	2,663	3,007	2,431	1,855
76	2,394	2,717	2,192	1,673	2,753	3,125	2,521	1,925
77	2,475	2,827	2,281	1,734	2,847	3,250	2,623	1,993
78	2,563	2,942	2,380	1,794	2,948	3,384	2,739	2,064
79	2,658	3,067	2,491	1,858	3,055	3,527	2,865	2,137
80	2,757	3,201	2,614	1,932	3,172	3,680	3,005	2,221
81	2,855	3,339	2,746	2,035	3,282	3,841	3,158	2,342
82	2,955	3,487	2,893	2,149	3,399	4,009	3,326	2,470
83	3,063	3,645	3,051	2,270	3,524	4,191	3,507	2,611
84	3,179	3,811	3,221	2,403	3,656	4,383	3,706	2,763
85	3,302	3,988	3,408	2,547	3,797	4,587	3,920	2,930
86	3,418	4,159	3,589	2,689	3,930	4,783	4,126	3,092
87	3,542	4,339	3,777	2,838	4,074	4,991	4,344	3,263
88	3,674	4,533	3,968	2,988	4,225	5,214	4,564	3,436
89	3,813	4,739	4,160	3,140	4,387	5,450	4,784	3,610
90	3,945	4,933	4,352	3,292	4,537	5,674	5,005	3,788
91	4,059	5,115	4,531	3,435	4,668	5,882	5,211	3,950
92	4,177	5,303	4,708	3,577	4,803	6,098	5,415	4,113
93	4,282	5,474	4,883	3,716	4,924	6,295	5,616	4,275
94	4,382	5,645	5,054	3,853	5,042	6,494	5,812	4,432
95	4,484	5,818	5,221	3,987	5,157	6,690	6,004	4,586
96	4,579	5,940	5,337	4,075	5,265	6,831	6,136	4,686
97	4,670	6,058	5,444	4,157	5,371	6,967	6,259	4,780
98	4,760	6,174	5,546	4,236	5,472	7,101	6,379	4,872
99	4,844	6,285	5,647	4,312	5,572	7,228	6,494	4,959

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

Semi Annual 1/2	Quarterly 1/4	Monthly 1/12
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There is a one-time \$25.00 policy fee.
A discount factor of .93 is applied for household applicants.

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 and zip code 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, and the policy fee will be refunded.

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 61 st thru 90 th day 91 st 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
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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 \$0 \$0	\$0 Up to \$204 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$240 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD 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
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 — 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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61 st thru 90 th day 91 st 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
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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$240 (Part B deductible) Generally 20%	 \$0 \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD 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
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 61 st thru 90 th day 91 st 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
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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$240 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	0%
BLOOD 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
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 — 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

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 61 st thru 90 th day 91 st 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
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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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* 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.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD 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
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	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.