

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

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 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%	✓	✓ Cops 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 OHIO ZIP CODES
436, 440-445

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,742	2,224	1,760	1,145	2,004	2,558	2,024	1,317
66	1,742	2,224	1,760	1,145	2,004	2,558	2,024	1,317
67	1,742	2,224	1,760	1,145	2,004	2,558	2,024	1,317
68	1,757	2,256	1,775	1,181	2,022	2,594	2,041	1,359
69	1,796	2,317	1,814	1,218	2,065	2,665	2,088	1,400
70	1,844	2,369	1,863	1,257	2,120	2,724	2,141	1,446
71	1,900	2,419	1,919	1,309	2,185	2,783	2,208	1,506
72	1,962	2,482	1,980	1,362	2,256	2,856	2,279	1,567
73	2,026	2,569	2,046	1,414	2,331	2,956	2,354	1,628
74	2,106	2,681	2,128	1,466	2,423	3,082	2,446	1,685
75	2,197	2,801	2,221	1,514	2,528	3,222	2,552	1,742
76	2,262	2,908	2,285	1,558	2,602	3,343	2,629	1,791
77	2,336	3,018	2,360	1,607	2,688	3,471	2,715	1,848
78	2,415	3,135	2,439	1,661	2,776	3,606	2,804	1,910
79	2,500	3,260	2,526	1,719	2,875	3,748	2,903	1,977
80	2,594	3,390	2,621	1,780	2,984	3,899	3,013	2,046
81	2,698	3,523	2,725	1,844	3,104	4,053	3,134	2,122
82	2,817	3,662	2,845	1,915	3,239	4,212	3,270	2,202
83	2,941	3,805	2,971	1,989	3,382	4,376	3,417	2,287
84	3,077	3,952	3,108	2,069	3,538	4,545	3,575	2,378
85	3,224	4,104	3,257	2,154	3,707	4,719	3,744	2,477
86	3,361	4,241	3,395	2,234	3,865	4,879	3,904	2,569
87	3,503	4,384	3,540	2,317	4,030	5,041	4,070	2,665
88	3,638	4,530	3,675	2,396	4,183	5,208	4,227	2,754
89	3,767	4,679	3,804	2,469	4,330	5,382	4,374	2,839
90	3,894	4,836	3,933	2,541	4,478	5,561	4,521	2,922
91	4,012	4,983	4,052	2,612	4,612	5,730	4,660	3,004
92	4,128	5,135	4,170	2,683	4,748	5,907	4,796	3,086
93	4,248	5,292	4,291	2,755	4,885	6,085	4,935	3,169
94	4,377	5,453	4,421	2,832	5,033	6,271	5,084	3,257
95	4,511	5,618	4,557	2,913	5,187	6,461	5,240	3,351
96	4,611	5,736	4,657	2,975	5,302	6,597	5,357	3,421
97	4,703	5,851	4,751	3,035	5,408	6,728	5,463	3,489
98	4,792	5,962	4,842	3,092	5,512	6,856	5,566	3,555
99	4,880	6,070	4,927	3,148	5,611	6,980	5,668	3,619

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 Premium Rates
FOR USE IN OHIO ZIP CODES
436, 440-445

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	2,004	2,558	2,024	1,317	2,305	2,942	2,327	1,514
66	2,004	2,558	2,024	1,317	2,305	2,942	2,327	1,514
67	2,004	2,558	2,024	1,317	2,305	2,942	2,327	1,514
68	2,022	2,594	2,041	1,359	2,323	2,984	2,348	1,562
69	2,065	2,665	2,088	1,400	2,376	3,064	2,400	1,610
70	2,120	2,724	2,141	1,446	2,439	3,132	2,464	1,662
71	2,185	2,783	2,208	1,506	2,512	3,200	2,538	1,731
72	2,256	2,856	2,279	1,567	2,594	3,283	2,621	1,802
73	2,331	2,956	2,354	1,628	2,680	3,398	2,707	1,871
74	2,423	3,082	2,446	1,685	2,785	3,543	2,813	1,939
75	2,528	3,222	2,552	1,742	2,908	3,705	2,938	2,002
76	2,602	3,343	2,629	1,791	2,993	3,844	3,022	2,060
77	2,688	3,471	2,715	1,848	3,090	3,992	3,121	2,125
78	2,776	3,606	2,804	1,910	3,193	4,146	3,227	2,197
79	2,875	3,748	2,903	1,977	3,306	4,311	3,339	2,273
80	2,984	3,899	3,013	2,046	3,431	4,483	3,464	2,354
81	3,104	4,053	3,134	2,122	3,567	4,660	3,605	2,440
82	3,239	4,212	3,270	2,202	3,724	4,843	3,762	2,532
83	3,382	4,376	3,417	2,287	3,890	5,032	3,929	2,629
84	3,538	4,545	3,575	2,378	4,069	5,227	4,109	2,735
85	3,707	4,719	3,744	2,477	4,263	5,426	4,308	2,849
86	3,865	4,879	3,904	2,569	4,445	5,609	4,489	2,955
87	4,030	5,041	4,070	2,665	4,635	5,797	4,680	3,064
88	4,183	5,208	4,227	2,754	4,813	5,989	4,860	3,168
89	4,330	5,382	4,374	2,839	4,981	6,190	5,030	3,264
90	4,478	5,561	4,521	2,922	5,150	6,395	5,201	3,361
91	4,612	5,730	4,660	3,004	5,305	6,590	5,359	3,456
92	4,748	5,907	4,796	3,086	5,459	6,792	5,516	3,548
93	4,885	6,085	4,935	3,169	5,619	6,998	5,675	3,644
94	5,033	6,271	5,084	3,257	5,787	7,211	5,845	3,745
95	5,187	6,461	5,240	3,351	5,966	7,430	6,027	3,852
96	5,302	6,597	5,357	3,421	6,098	7,586	6,159	3,933
97	5,408	6,728	5,463	3,489	6,220	7,737	6,282	4,012
98	5,512	6,856	5,566	3,555	6,338	7,885	6,402	4,089
99	5,611	6,980	5,668	3,619	6,452	8,026	6,516	4,162

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 Preferred Premium Rates
FOR USE IN OHIO ZIP CODES
450-454, 459

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,637	2,091	1,654	1,076	1,884	2,405	1,903	1,238
66	1,637	2,091	1,654	1,076	1,884	2,405	1,903	1,238
67	1,637	2,091	1,654	1,076	1,884	2,405	1,903	1,238
68	1,652	2,121	1,669	1,110	1,901	2,438	1,919	1,277
69	1,688	2,178	1,705	1,145	1,941	2,505	1,963	1,316
70	1,733	2,227	1,751	1,182	1,993	2,561	2,013	1,359
71	1,786	2,274	1,804	1,230	2,054	2,616	2,076	1,416
72	1,844	2,333	1,861	1,280	2,121	2,685	2,142	1,473
73	1,904	2,415	1,923	1,329	2,191	2,779	2,213	1,530
74	1,980	2,520	2,000	1,378	2,278	2,897	2,299	1,584
75	2,065	2,633	2,088	1,423	2,376	3,029	2,399	1,637
76	2,126	2,734	2,148	1,465	2,446	3,142	2,471	1,684
77	2,196	2,837	2,218	1,511	2,527	3,263	2,552	1,737
78	2,270	2,947	2,293	1,561	2,609	3,390	2,636	1,795
79	2,350	3,064	2,374	1,616	2,703	3,523	2,729	1,858
80	2,438	3,187	2,464	1,673	2,805	3,665	2,832	1,923
81	2,536	3,312	2,562	1,733	2,918	3,810	2,946	1,995
82	2,648	3,442	2,674	1,800	3,045	3,959	3,074	2,070
83	2,765	3,577	2,793	1,870	3,179	4,113	3,212	2,150
84	2,892	3,715	2,922	1,945	3,326	4,272	3,361	2,235
85	3,031	3,858	3,062	2,025	3,485	4,436	3,519	2,328
86	3,159	3,987	3,191	2,100	3,633	4,586	3,670	2,415
87	3,293	4,121	3,328	2,178	3,788	4,739	3,826	2,505
88	3,420	4,258	3,455	2,252	3,932	4,896	3,973	2,589
89	3,541	4,398	3,576	2,321	4,070	5,059	4,112	2,669
90	3,660	4,546	3,697	2,389	4,209	5,227	4,250	2,747
91	3,771	4,684	3,809	2,455	4,335	5,386	4,380	2,824
92	3,880	4,827	3,920	2,522	4,463	5,553	4,508	2,901
93	3,993	4,974	4,034	2,590	4,592	5,720	4,639	2,979
94	4,114	5,126	4,156	2,662	4,731	5,895	4,779	3,062
95	4,240	5,281	4,284	2,738	4,876	6,073	4,926	3,150
96	4,334	5,392	4,378	2,797	4,984	6,201	5,036	3,216
97	4,421	5,500	4,466	2,853	5,084	6,324	5,135	3,280
98	4,504	5,604	4,551	2,906	5,181	6,445	5,232	3,342
99	4,587	5,706	4,631	2,959	5,274	6,561	5,328	3,402

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 Premium Rates
FOR USE IN OHIO ZIP CODES
450-454, 459

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,884	2,405	1,903	1,238	2,167	2,765	2,187	1,423
66	1,884	2,405	1,903	1,238	2,167	2,765	2,187	1,423
67	1,884	2,405	1,903	1,238	2,167	2,765	2,187	1,423
68	1,901	2,438	1,919	1,277	2,184	2,805	2,207	1,468
69	1,941	2,505	1,963	1,316	2,233	2,880	2,256	1,513
70	1,993	2,561	2,013	1,359	2,293	2,944	2,316	1,562
71	2,054	2,616	2,076	1,416	2,361	3,008	2,386	1,627
72	2,121	2,685	2,142	1,473	2,438	3,086	2,464	1,694
73	2,191	2,779	2,213	1,530	2,519	3,194	2,545	1,759
74	2,278	2,897	2,299	1,584	2,618	3,330	2,644	1,823
75	2,376	3,029	2,399	1,637	2,734	3,483	2,762	1,882
76	2,446	3,142	2,471	1,684	2,813	3,613	2,841	1,936
77	2,527	3,263	2,552	1,737	2,905	3,752	2,934	1,998
78	2,609	3,390	2,636	1,795	3,001	3,897	3,033	2,065
79	2,703	3,523	2,729	1,858	3,108	4,052	3,139	2,137
80	2,805	3,665	2,832	1,923	3,225	4,214	3,256	2,213
81	2,918	3,810	2,946	1,995	3,353	4,380	3,389	2,294
82	3,045	3,959	3,074	2,070	3,501	4,552	3,536	2,380
83	3,179	4,113	3,212	2,150	3,657	4,730	3,693	2,471
84	3,326	4,272	3,361	2,235	3,825	4,913	3,862	2,571
85	3,485	4,436	3,519	2,328	4,007	5,100	4,050	2,678
86	3,633	4,586	3,670	2,415	4,178	5,272	4,220	2,778
87	3,788	4,739	3,826	2,505	4,357	5,449	4,399	2,880
88	3,932	4,896	3,973	2,589	4,524	5,630	4,568	2,978
89	4,070	5,059	4,112	2,669	4,682	5,819	4,728	3,068
90	4,209	5,227	4,250	2,747	4,841	6,011	4,889	3,159
91	4,335	5,386	4,380	2,824	4,987	6,195	5,037	3,249
92	4,463	5,553	4,508	2,901	5,131	6,384	5,185	3,335
93	4,592	5,720	4,639	2,979	5,282	6,578	5,335	3,425
94	4,731	5,895	4,779	3,062	5,440	6,778	5,494	3,520
95	4,876	6,073	4,926	3,150	5,608	6,984	5,665	3,621
96	4,984	6,201	5,036	3,216	5,732	7,131	5,789	3,697
97	5,084	6,324	5,135	3,280	5,847	7,273	5,905	3,771
98	5,181	6,445	5,232	3,342	5,958	7,412	6,018	3,844
99	5,274	6,561	5,328	3,402	6,065	7,544	6,125	3,912

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 Preferred Premium Rates
FOR USE IN OHIO ZIP CODES ALL EXCEPT
436, 440-445, 450-454, 459

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,550	1,979	1,566	1,019	1,784	2,277	1,801	1,172
66	1,550	1,979	1,566	1,019	1,784	2,277	1,801	1,172
67	1,550	1,979	1,566	1,019	1,784	2,277	1,801	1,172
68	1,564	2,008	1,580	1,051	1,800	2,309	1,816	1,210
69	1,598	2,062	1,614	1,084	1,838	2,372	1,858	1,246
70	1,641	2,108	1,658	1,119	1,887	2,424	1,905	1,287
71	1,691	2,153	1,708	1,165	1,945	2,477	1,965	1,340
72	1,746	2,209	1,762	1,212	2,008	2,542	2,028	1,395
73	1,803	2,286	1,821	1,258	2,075	2,631	2,095	1,449
74	1,874	2,386	1,894	1,305	2,156	2,743	2,177	1,500
75	1,955	2,493	1,977	1,347	2,250	2,868	2,271	1,550
76	2,013	2,588	2,034	1,387	2,316	2,975	2,340	1,594
77	2,079	2,686	2,100	1,430	2,392	3,089	2,416	1,645
78	2,149	2,790	2,171	1,478	2,471	3,209	2,496	1,700
79	2,225	2,901	2,248	1,530	2,559	3,336	2,584	1,760
80	2,309	3,017	2,333	1,584	2,656	3,470	2,682	1,821
81	2,401	3,135	2,425	1,641	2,763	3,607	2,789	1,889
82	2,507	3,259	2,532	1,704	2,883	3,749	2,910	1,960
83	2,617	3,386	2,644	1,770	3,010	3,895	3,041	2,035
84	2,739	3,517	2,766	1,841	3,149	4,045	3,182	2,116
85	2,869	3,653	2,899	1,917	3,299	4,200	3,332	2,205
86	2,991	3,774	3,022	1,988	3,440	4,342	3,475	2,286
87	3,118	3,902	3,151	2,062	3,587	4,486	3,622	2,372
88	3,238	4,032	3,271	2,132	3,723	4,635	3,762	2,451
89	3,353	4,164	3,386	2,197	3,854	4,790	3,893	2,527
90	3,466	4,304	3,500	2,261	3,985	4,949	4,024	2,601
91	3,571	4,435	3,606	2,325	4,105	5,100	4,147	2,674
92	3,674	4,570	3,711	2,388	4,226	5,257	4,268	2,747
93	3,781	4,710	3,819	2,452	4,348	5,416	4,392	2,820
94	3,896	4,853	3,935	2,520	4,479	5,581	4,525	2,899
95	4,015	5,000	4,056	2,593	4,616	5,750	4,664	2,982
96	4,104	5,105	4,145	2,648	4,719	5,871	4,768	3,045
97	4,186	5,207	4,228	2,701	4,813	5,988	4,862	3,105
98	4,265	5,306	4,309	2,752	4,906	6,102	4,954	3,164
99	4,343	5,402	4,385	2,802	4,994	6,212	5,045	3,221

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 Premium Rates
FOR USE IN OHIO ZIP CODES ALL EXCEPT
436, 440-445, 450-454, 459

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,784	2,277	1,801	1,172	2,051	2,618	2,071	1,347
66	1,784	2,277	1,801	1,172	2,051	2,618	2,071	1,347
67	1,784	2,277	1,801	1,172	2,051	2,618	2,071	1,347
68	1,800	2,309	1,816	1,210	2,067	2,656	2,090	1,390
69	1,838	2,372	1,858	1,246	2,115	2,727	2,136	1,433
70	1,887	2,424	1,905	1,287	2,171	2,787	2,193	1,479
71	1,945	2,477	1,965	1,340	2,236	2,848	2,259	1,541
72	2,008	2,542	2,028	1,395	2,309	2,922	2,333	1,604
73	2,075	2,631	2,095	1,449	2,385	3,024	2,409	1,665
74	2,156	2,743	2,177	1,500	2,479	3,153	2,504	1,726
75	2,250	2,868	2,271	1,550	2,588	3,297	2,615	1,782
76	2,316	2,975	2,340	1,594	2,664	3,421	2,690	1,833
77	2,392	3,089	2,416	1,645	2,750	3,553	2,778	1,891
78	2,471	3,209	2,496	1,700	2,842	3,690	2,872	1,955
79	2,559	3,336	2,584	1,760	2,942	3,837	2,972	2,023
80	2,656	3,470	2,682	1,821	3,054	3,990	3,083	2,095
81	2,763	3,607	2,789	1,889	3,175	4,147	3,208	2,172
82	2,883	3,749	2,910	1,960	3,314	4,310	3,348	2,253
83	3,010	3,895	3,041	2,035	3,462	4,478	3,497	2,340
84	3,149	4,045	3,182	2,116	3,621	4,652	3,657	2,434
85	3,299	4,200	3,332	2,205	3,794	4,829	3,834	2,536
86	3,440	4,342	3,475	2,286	3,956	4,992	3,995	2,630
87	3,587	4,486	3,622	2,372	4,125	5,159	4,165	2,727
88	3,723	4,635	3,762	2,451	4,284	5,330	4,325	2,820
89	3,854	4,790	3,893	2,527	4,433	5,509	4,477	2,905
90	3,985	4,949	4,024	2,601	4,584	5,692	4,629	2,991
91	4,105	5,100	4,147	2,674	4,721	5,865	4,770	3,076
92	4,226	5,257	4,268	2,747	4,859	6,045	4,909	3,158
93	4,348	5,416	4,392	2,820	5,001	6,228	5,051	3,243
94	4,479	5,581	4,525	2,899	5,150	6,418	5,202	3,333
95	4,616	5,750	4,664	2,982	5,310	6,613	5,364	3,428
96	4,719	5,871	4,768	3,045	5,427	6,752	5,482	3,500
97	4,813	5,988	4,862	3,105	5,536	6,886	5,591	3,571
98	4,906	6,102	4,954	3,164	5,641	7,018	5,698	3,639
99	4,994	6,212	5,045	3,221	5,742	7,143	5,799	3,704

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

PREMIUM INFORMATION

We, ManhattanLife Insurance and Annuity Company, can only raise your premium if we raise the premium for all policies like yours in this State, you enter a new age category, or your residence changes such that you move to a new rating area.

NON-TOBACCO OR TOBACCO PREMIUMS

You are eligible for Non-Tobacco premiums if:

- you apply for ManhattanLife Insurance and Annuity Company's Medicare supplement insurance during your open enrollment or guaranteed issue period; or,
- you answered, "No," on your application where we required you to answer as to whether or not you have used any form of tobacco, an electronic cigarette (e-cig), or other nicotine products in the last 12 months.

HOUSEHOLD DISCOUNT

You are eligible for the Household Discount if:

- you have resided for the last 12 months with someone that has an existing Medicare Supplement Policy with ManhattanLife Insurance and Annuity Company, The Manhattan Life Insurance Company, or Family Life Insurance Company.
- the Household Discount will be removed if the other Medicare supplement policyholder chooses to terminate his or her Medicare Supplement policy, or if he or she no longer resides with you.

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.

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.

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*	\$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 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*	\$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 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.