

**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 <sup>1</sup>	K	L	M	N	C	F	F <sup>1</sup>
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Medicare Part B coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓ Copays apply <sup>3</sup>	✓	✓	
Blood (first three pints)	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Part A hospice care coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Skilled nursing facility coinsurance			✓	✓		50%	75%	✓	✓	✓	✓	
Medicare Part A deductible		✓	✓	✓		50%	75%	50%	✓	✓	✓	
Medicare Part B deductible										✓	✓	
Medicare Part B excess charges				✓							✓	
Foreign travel emergency (up to plan limits)			✓	✓				✓	✓	✓	✓	
Out-of-pocket limit in 2024 <sup>2</sup>						\$7,060 <sup>2</sup>	\$3,530 <sup>2</sup>					

<sup>1</sup> Plans F and G also have a high deductible option, which require first paying a plan deductible of \$2,800 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

<sup>2</sup> Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

<sup>3</sup> Plan N pays 100% of the Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that do not result in an inpatient admission.

**ManhattanLife Insurance and Annuity Company**  
**Annual Preferred (Non-Smoking) Premium Rates**  
**FOR USE IN WEST VIRGINIA ZIP CODES**  
**247-268**

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,579	1,849	1,460	1,077	1,815	2,127	1,681	1,238
66	1,596	1,862	1,474	1,088	1,835	2,140	1,694	1,252
67	1,607	1,874	1,483	1,098	1,850	2,155	1,706	1,264
68	1,626	1,889	1,494	1,129	1,872	2,172	1,718	1,297
69	1,675	1,942	1,543	1,163	1,926	2,234	1,775	1,337
70	1,728	2,000	1,596	1,199	1,987	2,300	1,835	1,379
71	1,780	2,063	1,649	1,249	2,047	2,373	1,897	1,436
72	1,833	2,128	1,706	1,298	2,107	2,446	1,962	1,493
73	1,883	2,192	1,762	1,348	2,167	2,520	2,027	1,551
74	1,955	2,278	1,825	1,407	2,247	2,618	2,098	1,617
75	2,036	2,375	1,891	1,470	2,340	2,731	2,173	1,692
76	2,100	2,466	1,950	1,525	2,416	2,837	2,243	1,754
77	2,172	2,563	2,020	1,581	2,496	2,948	2,322	1,817
78	2,245	2,665	2,091	1,637	2,581	3,064	2,405	1,883
79	2,326	2,776	2,175	1,695	2,674	3,192	2,502	1,949
80	2,411	2,893	2,272	1,762	2,773	3,328	2,614	2,026
81	2,493	3,016	2,388	1,857	2,867	3,470	2,745	2,135
82	2,579	3,147	2,510	1,960	2,965	3,620	2,888	2,254
83	2,670	3,287	2,646	2,071	3,071	3,779	3,041	2,382
84	2,769	3,433	2,793	2,192	3,184	3,948	3,210	2,520
85	2,873	3,588	2,951	2,324	3,304	4,127	3,393	2,672
86	2,971	3,739	3,107	2,451	3,417	4,300	3,572	2,820
87	3,077	3,897	3,267	2,588	3,537	4,483	3,756	2,976
88	3,187	4,067	3,428	2,726	3,666	4,677	3,942	3,134
89	3,302	4,244	3,589	2,864	3,798	4,879	4,128	3,294
90	3,417	4,418	3,752	3,003	3,927	5,081	4,315	3,453
91	3,515	4,580	3,903	3,133	4,041	5,268	4,488	3,604
92	3,616	4,748	4,052	3,263	4,160	5,459	4,661	3,751
93	3,707	4,902	4,200	3,389	4,264	5,638	4,829	3,898
94	3,796	5,057	4,341	3,516	4,365	5,815	4,994	4,041
95	3,883	5,209	4,480	3,637	4,466	5,991	5,153	4,182
96	3,964	5,319	4,575	3,717	4,559	6,116	5,263	4,275
97	4,044	5,425	4,662	3,791	4,651	6,239	5,360	4,360
98	4,122	5,530	4,746	3,863	4,738	6,357	5,457	4,443
99	4,195	5,628	4,826	3,933	4,825	6,471	5,550	4,522

Household Discount Factor: .93

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

Semi Annual  
1/2

Quarterly  
1/4

Monthly  
1/12

**ManhattanLife Insurance and Annuity Company**  
**Annual Standard (Smoking) Premium Rates**  
**FOR USE IN WEST VIRGINIA ZIP CODES**  
**247-268**

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,815	2,127	1,681	1,238	2,086	2,445	1,933	1,425
66	1,835	2,140	1,694	1,252	2,109	2,464	1,949	1,440
67	1,850	2,155	1,706	1,264	2,128	2,478	1,961	1,453
68	1,872	2,172	1,718	1,297	2,151	2,498	1,976	1,493
69	1,926	2,234	1,775	1,337	2,215	2,569	2,042	1,538
70	1,987	2,300	1,835	1,379	2,286	2,643	2,109	1,585
71	2,047	2,373	1,897	1,436	2,355	2,728	2,181	1,651
72	2,107	2,446	1,962	1,493	2,423	2,813	2,255	1,717
73	2,167	2,520	2,027	1,551	2,492	2,898	2,331	1,784
74	2,247	2,618	2,098	1,617	2,585	3,013	2,413	1,860
75	2,340	2,731	2,173	1,692	2,691	3,141	2,501	1,945
76	2,416	2,837	2,243	1,754	2,779	3,262	2,578	2,018
77	2,496	2,948	2,322	1,817	2,871	3,390	2,670	2,092
78	2,581	3,064	2,405	1,883	2,968	3,524	2,766	2,165
79	2,674	3,192	2,502	1,949	3,077	3,671	2,876	2,240
80	2,773	3,328	2,614	2,026	3,188	3,827	3,006	2,330
81	2,867	3,470	2,745	2,135	3,297	3,990	3,156	2,456
82	2,965	3,620	2,888	2,254	3,410	4,162	3,321	2,592
83	3,071	3,779	3,041	2,382	3,532	4,346	3,499	2,739
84	3,184	3,948	3,210	2,520	3,661	4,541	3,693	2,899
85	3,304	4,127	3,393	2,672	3,798	4,746	3,902	3,072
86	3,417	4,300	3,572	2,820	3,928	4,944	4,108	3,244
87	3,537	4,483	3,756	2,976	4,067	5,155	4,320	3,423
88	3,666	4,677	3,942	3,134	4,214	5,379	4,534	3,605
89	3,798	4,879	4,128	3,294	4,368	5,611	4,748	3,788
90	3,927	5,081	4,315	3,453	4,517	5,843	4,962	3,972
91	4,041	5,268	4,488	3,604	4,648	6,057	5,162	4,144
92	4,160	5,459	4,661	3,751	4,783	6,279	5,360	4,314
93	4,264	5,638	4,829	3,898	4,902	6,483	5,554	4,483
94	4,365	5,815	4,994	4,041	5,020	6,687	5,743	4,648
95	4,466	5,991	5,153	4,182	5,135	6,889	5,926	4,809
96	4,559	6,116	5,263	4,275	5,244	7,035	6,050	4,915
97	4,651	6,239	5,360	4,360	5,349	7,175	6,165	5,013
98	4,738	6,357	5,457	4,443	5,450	7,311	6,276	5,109
99	4,825	6,471	5,550	4,522	5,547	7,444	6,383	5,201

Household Discount Factor: .93

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

Semi Annual  
1/2

Quarterly  
1/4

Monthly  
1/12

### **PREMIUM INFORMATION**

ManhattanLife Insurance and Annuity Company may change your premium if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class on the date of change. Class is defined as attained age, underwriting class, and state of residence.

Premiums are based on your attained age and will change on Your Policy Anniversary Date.

### **DISCLOSURES**

Use this outline to compare benefits and premiums among policies.

### **READ YOUR POLICY VERY CAREFULLY**

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and ManhattanLife Insurance and Annuity Company.

### **RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to our Medicare Supplement Administrative Office at P. O. Box 925568, Houston, Texas 77292-5568. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

### **POLICY REPLACEMENT**

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

### **NOTICE**

This policy may not fully cover all of your medical costs. Neither ManhattanLife Insurance and Annuity Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

### **LIMITATIONS AND EXCLUSIONS**

This Policy does not pay expenses related to any coverage that is limited or excluded by Medicare related to services not "reasonable and Medically Necessary" under the Medicare Program Standards for diagnosis or treatment of Injury or Sickness.

### **REFUND OF PREMIUMS**

The Policy does contain a Pro-Rata Refund provision which provides for the partial refund of premium upon death.

The Policy does contain a Cancellation By Insured provision which provides for a refund of premium upon surrender of the Policy.

### **COMPLETE ANSWERS ARE VERY IMPORTANT**

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

**Review the application carefully before you sign it. Be certain that all information has been properly recorded.**

**Please refer to your policy for details.**

**PLAN A**  
**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day  All but \$816 a day  \$0  \$0	\$0 \$408 a day  \$816 a day  100% of Medicare eligible expenses  \$0	\$1632 (Part A deductible) \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$204 a day \$0	\$0 \$0 \$0	\$0 Up to \$204 a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for 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
<b>MEDICAL EXPENSES –</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	       \$0 Generally 80%	       \$0 Generally 20%	       \$240 (Part B deductible) \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$240 (Part B deductible) \$0
<b>CLINICAL LABORATORY            SERVICES – TESTS FOR            DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

## PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	       100% \$0 80%	       \$0 \$0 20%	       \$0 \$240 (Part B deductible) \$0

## PLAN F

### MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day  All but \$816 a day  \$0  \$0	\$1632 (Part A deductible) \$408 a day  \$816 a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN F**

**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\*Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES –</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$240 (Part B deductible)  Generally 20%	\$0  \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$240 of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 \$0 80%	All costs \$240 (Part B deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%  \$0 80%	\$0 \$240 (Part B deductible) 20%	\$0 \$0 \$0

**OTHER SERVICES – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum



## PLAN G

### MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day  All but \$816 a day  \$0  \$0	\$1632 (Part A deductible) \$408 a day  \$816 a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for 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
<b>MEDICAL EXPENSES –</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	      \$0 Generally 80%	      \$0 Generally 20%	      \$240 (Part B deductible) \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	0%
<b>BLOOD</b> First 3 pints Next \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$240 (Part B deductible) \$0
<b>CLINICAL LABORATORY            SERVICES – TESTS FOR            DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> <b>MEDICARE APPROVED</b> <b>SERVICES</b> — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	      100% \$0 80%	      \$0 \$0 20%	      \$0 \$240 (Part B deductible) \$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	   \$0 \$0	   \$0 80% to a lifetime maximum benefit of \$50,000.	   \$250 20% and amounts over the \$50,000 lifetime maximum

## PLAN N

### MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day  All but \$816 a day  \$0  \$0	\$1632 (Part A deductible) \$408 a day  \$816 a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for 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
<b>MEDICAL EXPENSES –</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The co- payment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$240 (Part B deductible)  Up to \$20 per office visit and up to \$50 per emergency room visit. The co-payment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$240 (Part B deductible) \$0
<b>CLINICAL LABORATORY            SERVICES – TESTS FOR            DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000.	20% and amounts over the \$50,000 lifetime maximum.