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 ALABAMA ZIP CODES
350-352, 355

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,553	1,933	1,480	1,128	1,787	2,224	1,702	1,296
66	1,553	1,933	1,480	1,128	1,787	2,224	1,702	1,296
67	1,553	1,933	1,480	1,128	1,787	2,224	1,702	1,296
68	1,587	1,969	1,483	1,164	1,826	2,263	1,706	1,338
69	1,644	2,024	1,532	1,200	1,890	2,327	1,762	1,379
70	1,701	2,073	1,584	1,234	1,957	2,384	1,822	1,418
71	1,751	2,140	1,637	1,283	2,016	2,460	1,882	1,474
72	1,802	2,205	1,693	1,331	2,074	2,536	1,947	1,530
73	1,854	2,273	1,749	1,381	2,133	2,611	2,011	1,587
74	1,924	2,338	1,815	1,434	2,212	2,688	2,088	1,649
75	2,004	2,440	1,892	1,486	2,306	2,807	2,176	1,709
76	2,072	2,538	1,960	1,540	2,383	2,917	2,254	1,772
77	2,142	2,639	2,041	1,597	2,464	3,035	2,347	1,835
78	2,219	2,748	2,131	1,653	2,551	3,159	2,450	1,901
79	2,300	2,864	2,230	1,712	2,646	3,294	2,563	1,968
80	2,387	2,989	2,339	1,779	2,744	3,436	2,689	2,045
81	2,470	3,119	2,457	1,874	2,841	3,586	2,826	2,155
82	2,558	3,256	2,588	1,978	2,942	3,744	2,976	2,276
83	2,652	3,402	2,730	2,091	3,049	3,914	3,139	2,404
84	2,752	3,559	2,883	2,213	3,163	4,092	3,315	2,545
85	2,858	3,723	3,050	2,346	3,286	4,282	3,508	2,699
86	2,958	3,882	3,212	2,477	3,402	4,465	3,691	2,848
87	3,066	4,052	3,380	2,613	3,526	4,659	3,886	3,005
88	3,179	4,233	3,550	2,752	3,657	4,866	4,083	3,165
89	3,302	4,425	3,722	2,893	3,795	5,088	4,280	3,325
90	3,415	4,616	3,892	3,032	3,926	5,308	4,477	3,487
91	3,513	4,795	4,055	3,164	4,039	5,513	4,661	3,638
92	3,615	4,969	4,213	3,294	4,158	5,714	4,845	3,788
93	3,706	5,141	4,370	3,423	4,262	5,912	5,027	3,936
94	3,793	5,308	4,523	3,549	4,364	6,104	5,202	4,081
95	3,881	5,468	4,672	3,673	4,463	6,289	5,373	4,223
96	3,963	5,582	4,775	3,753	4,557	6,422	5,492	4,317
97	4,041	5,696	4,871	3,828	4,649	6,549	5,601	4,402
98	4,120	5,804	4,963	3,900	4,737	6,675	5,708	4,486
99	4,193	5,909	5,052	3,971	4,823	6,794	5,810	4,568

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 policy fee.

A discount factor of .93 is applied for household applicants.

ManhattanLife Insurance and Annuity Company
Annual Standard Premium Rates
FOR USE IN ALABAMA ZIP CODES
350-352, 355

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,787	2,224	1,702	1,296	2,055	2,555	1,957	1,492
66	1,787	2,224	1,702	1,296	2,055	2,555	1,957	1,492
67	1,787	2,224	1,702	1,296	2,055	2,555	1,957	1,492
68	1,826	2,263	1,706	1,338	2,100	2,602	1,961	1,539
69	1,890	2,327	1,762	1,379	2,174	2,676	2,027	1,584
70	1,957	2,384	1,822	1,418	2,250	2,741	2,095	1,631
71	2,016	2,460	1,882	1,474	2,317	2,829	2,164	1,695
72	2,074	2,536	1,947	1,530	2,385	2,916	2,240	1,761
73	2,133	2,611	2,011	1,587	2,452	3,005	2,313	1,825
74	2,212	2,688	2,088	1,649	2,544	3,093	2,401	1,896
75	2,306	2,807	2,176	1,709	2,651	3,227	2,501	1,965
76	2,383	2,917	2,254	1,772	2,740	3,354	2,594	2,037
77	2,464	3,035	2,347	1,835	2,834	3,490	2,699	2,111
78	2,551	3,159	2,450	1,901	2,934	3,633	2,817	2,186
79	2,646	3,294	2,563	1,968	3,042	3,788	2,948	2,263
80	2,744	3,436	2,689	2,045	3,156	3,951	3,092	2,352
81	2,841	3,586	2,826	2,155	3,266	4,123	3,251	2,480
82	2,942	3,744	2,976	2,276	3,383	4,305	3,422	2,616
83	3,049	3,914	3,139	2,404	3,507	4,500	3,610	2,765
84	3,163	4,092	3,315	2,545	3,639	4,705	3,813	2,926
85	3,286	4,282	3,508	2,699	3,779	4,925	4,033	3,103
86	3,402	4,465	3,691	2,848	3,912	5,135	4,245	3,275
87	3,526	4,659	3,886	3,005	4,055	5,359	4,471	3,456
88	3,657	4,866	4,083	3,165	4,205	5,598	4,695	3,639
89	3,795	5,088	4,280	3,325	4,367	5,852	4,923	3,825
90	3,926	5,308	4,477	3,487	4,516	6,104	5,148	4,010
91	4,039	5,513	4,661	3,638	4,647	6,340	5,361	4,183
92	4,158	5,714	4,845	3,788	4,782	6,572	5,572	4,356
93	4,262	5,912	5,027	3,936	4,900	6,798	5,779	4,527
94	4,364	6,104	5,202	4,081	5,017	7,020	5,982	4,693
95	4,463	6,289	5,373	4,223	5,134	7,233	6,178	4,856
96	4,557	6,422	5,492	4,317	5,242	7,385	6,315	4,963
97	4,649	6,549	5,601	4,402	5,346	7,532	6,441	5,062
98	4,737	6,675	5,708	4,486	5,448	7,674	6,564	5,158
99	4,823	6,794	5,810	4,568	5,545	7,814	6,682	5,252

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 policy fee.

A discount factor of .93 is applied for household applicants.

ManhattanLife Insurance and Annuity Company
Annual Preferred Premium Rates
FOR USE IN ALABAMA ZIP CODES
353-354, 356-369

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,416	1,762	1,349	1,029	1,629	2,027	1,552	1,182
66	1,416	1,762	1,349	1,029	1,629	2,027	1,552	1,182
67	1,416	1,762	1,349	1,029	1,629	2,027	1,552	1,182
68	1,447	1,795	1,352	1,061	1,665	2,064	1,556	1,220
69	1,499	1,845	1,397	1,094	1,723	2,121	1,606	1,257
70	1,551	1,890	1,444	1,125	1,785	2,173	1,661	1,293
71	1,597	1,951	1,493	1,170	1,838	2,243	1,716	1,344
72	1,643	2,011	1,544	1,214	1,891	2,312	1,775	1,395
73	1,691	2,072	1,595	1,259	1,945	2,381	1,834	1,447
74	1,754	2,132	1,654	1,308	2,017	2,451	1,904	1,504
75	1,827	2,225	1,725	1,355	2,103	2,559	1,984	1,558
76	1,889	2,314	1,787	1,404	2,172	2,660	2,055	1,615
77	1,953	2,406	1,861	1,456	2,247	2,767	2,140	1,673
78	2,023	2,505	1,943	1,508	2,326	2,880	2,234	1,734
79	2,097	2,611	2,033	1,561	2,412	3,003	2,337	1,794
80	2,176	2,725	2,132	1,622	2,502	3,133	2,451	1,865
81	2,252	2,844	2,240	1,708	2,590	3,270	2,577	1,965
82	2,332	2,969	2,359	1,803	2,682	3,414	2,714	2,075
83	2,418	3,102	2,489	1,907	2,780	3,568	2,862	2,192
84	2,509	3,245	2,628	2,018	2,884	3,731	3,023	2,320
85	2,606	3,395	2,781	2,139	2,996	3,904	3,198	2,461
86	2,697	3,540	2,929	2,258	3,102	4,071	3,366	2,597
87	2,796	3,695	3,082	2,383	3,215	4,248	3,543	2,740
88	2,899	3,860	3,236	2,509	3,334	4,437	3,723	2,886
89	3,010	4,034	3,394	2,637	3,461	4,639	3,902	3,032
90	3,114	4,208	3,549	2,765	3,580	4,840	4,082	3,180
91	3,203	4,372	3,697	2,885	3,683	5,027	4,250	3,317
92	3,296	4,531	3,841	3,003	3,791	5,210	4,418	3,454
93	3,379	4,687	3,984	3,121	3,886	5,390	4,583	3,589
94	3,459	4,840	4,124	3,235	3,979	5,565	4,743	3,721
95	3,539	4,986	4,259	3,349	4,069	5,734	4,899	3,850
96	3,613	5,090	4,353	3,421	4,155	5,855	5,007	3,936
97	3,685	5,193	4,441	3,490	4,239	5,972	5,107	4,014
98	3,756	5,292	4,525	3,556	4,319	6,086	5,204	4,090
99	3,823	5,387	4,606	3,620	4,397	6,195	5,297	4,165

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 policy fee.

A discount factor of .93 is applied for household applicants.

ManhattanLife Insurance and Annuity Company
Annual Standard Premium Rates
FOR USE IN ALABAMA ZIP CODES
353-354, 356-369

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,629	2,027	1,552	1,182	1,874	2,330	1,785	1,361
66	1,629	2,027	1,552	1,182	1,874	2,330	1,785	1,361
67	1,629	2,027	1,552	1,182	1,874	2,330	1,785	1,361
68	1,665	2,064	1,556	1,220	1,915	2,372	1,788	1,403
69	1,723	2,121	1,606	1,257	1,982	2,440	1,848	1,444
70	1,785	2,173	1,661	1,293	2,052	2,499	1,910	1,487
71	1,838	2,243	1,716	1,344	2,113	2,580	1,973	1,546
72	1,891	2,312	1,775	1,395	2,174	2,659	2,042	1,605
73	1,945	2,381	1,834	1,447	2,236	2,740	2,109	1,664
74	2,017	2,451	1,904	1,504	2,319	2,820	2,189	1,729
75	2,103	2,559	1,984	1,558	2,417	2,943	2,280	1,791
76	2,172	2,660	2,055	1,615	2,498	3,058	2,365	1,857
77	2,247	2,767	2,140	1,673	2,584	3,182	2,461	1,925
78	2,326	2,880	2,234	1,734	2,675	3,313	2,569	1,993
79	2,412	3,003	2,337	1,794	2,773	3,454	2,688	2,064
80	2,502	3,133	2,451	1,865	2,877	3,603	2,819	2,145
81	2,590	3,270	2,577	1,965	2,978	3,759	2,964	2,261
82	2,682	3,414	2,714	2,075	3,085	3,926	3,120	2,385
83	2,780	3,568	2,862	2,192	3,197	4,103	3,291	2,521
84	2,884	3,731	3,023	2,320	3,318	4,290	3,476	2,668
85	2,996	3,904	3,198	2,461	3,446	4,490	3,677	2,829
86	3,102	4,071	3,366	2,597	3,567	4,682	3,871	2,986
87	3,215	4,248	3,543	2,740	3,697	4,886	4,076	3,151
88	3,334	4,437	3,723	2,886	3,834	5,104	4,281	3,318
89	3,461	4,639	3,902	3,032	3,981	5,335	4,488	3,488
90	3,580	4,840	4,082	3,180	4,117	5,565	4,694	3,656
91	3,683	5,027	4,250	3,317	4,237	5,781	4,888	3,814
92	3,791	5,210	4,418	3,454	4,360	5,992	5,081	3,972
93	3,886	5,390	4,583	3,589	4,468	6,198	5,269	4,127
94	3,979	5,565	4,743	3,721	4,575	6,400	5,454	4,279
95	4,069	5,734	4,899	3,850	4,681	6,595	5,633	4,428
96	4,155	5,855	5,007	3,936	4,779	6,733	5,758	4,525
97	4,239	5,972	5,107	4,014	4,874	6,867	5,873	4,616
98	4,319	6,086	5,204	4,090	4,967	6,997	5,985	4,703
99	4,397	6,195	5,297	4,165	5,055	7,125	6,092	4,789

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 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, state and zip code of residence.

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

Premiums for other Medicare supplement policies that are issue age or community rated do not increase due to changes in the policyholder's age.

You should compare other Medicare Supplement policies that are issue age bases to policies of attained age bases. While the cost of the policy at the covered individuals present age may be lower than the cost of a Medicare supplement policy based on issue age or community rating, it is important to compare the potential cost of these policies over the life of the policy.

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 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) Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force; (c) That portion of any expense incurred which is paid for by Medicare; (d) Services for non-Medicare Eligible Expenses unless specifically covered in the policy, including, but not limited to, routine exams, take-home drugs and eye refractions; (e) Services for which a charge is not normally made in the absence of insurance; or (f) Loss or expense that is payable under any other Medicare Supplement insurance policy or certificate.

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	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.