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 ATTAINED AGE PREMIUMS
FOR USE IN IOWA ZIP CODES
503, 515

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,704	1,973	1,609	1,083	1,959	2,270	1,850	1,245
66	1,704	1,973	1,609	1,083	1,959	2,270	1,850	1,245
67	1,704	1,973	1,609	1,083	1,959	2,270	1,850	1,245
68	1,739	2,010	1,630	1,117	2,001	2,311	1,875	1,286
69	1,801	2,077	1,674	1,151	2,071	2,387	1,926	1,324
70	1,865	2,143	1,722	1,188	2,144	2,465	1,980	1,365
71	1,919	2,213	1,779	1,238	2,209	2,545	2,048	1,421
72	1,976	2,281	1,840	1,287	2,273	2,624	2,117	1,480
73	2,032	2,351	1,902	1,337	2,337	2,703	2,189	1,537
74	2,108	2,442	1,974	1,388	2,425	2,809	2,270	1,595
75	2,197	2,551	2,054	1,445	2,526	2,932	2,362	1,661
76	2,271	2,650	2,129	1,499	2,612	3,049	2,449	1,722
77	2,349	2,758	2,218	1,552	2,701	3,172	2,551	1,785
78	2,432	2,869	2,315	1,608	2,796	3,301	2,661	1,848
79	2,521	2,992	2,421	1,663	2,900	3,441	2,785	1,914
80	2,616	3,120	2,539	1,730	3,008	3,591	2,920	1,989
81	2,707	3,258	2,670	1,822	3,114	3,746	3,069	2,097
82	2,804	3,402	2,812	1,924	3,224	3,912	3,231	2,212
83	2,907	3,556	2,965	2,034	3,342	4,089	3,409	2,338
84	3,016	3,718	3,131	2,152	3,468	4,275	3,601	2,474
85	3,131	3,891	3,312	2,281	3,602	4,474	3,810	2,622
86	3,243	4,059	3,487	2,408	3,728	4,666	4,010	2,768
87	3,361	4,234	3,671	2,542	3,865	4,869	4,221	2,922
88	3,485	4,422	3,856	2,675	4,009	5,086	4,435	3,076
89	3,620	4,623	4,042	2,812	4,160	5,316	4,649	3,234
90	3,742	4,814	4,229	2,948	4,304	5,535	4,863	3,392
91	3,851	4,989	4,403	3,075	4,428	5,739	5,064	3,538
92	3,963	5,172	4,576	3,203	4,557	5,950	5,263	3,683
93	4,061	5,342	4,746	3,328	4,672	6,142	5,458	3,826
94	4,158	5,509	4,913	3,451	4,781	6,334	5,650	3,968
95	4,254	5,675	5,074	3,571	4,892	6,527	5,838	4,106
96	4,344	5,795	5,185	3,649	4,995	6,664	5,965	4,197
97	4,431	5,911	5,290	3,722	5,095	6,796	6,083	4,279
98	4,515	6,022	5,390	3,793	5,192	6,927	6,200	4,362
99	4,596	6,132	5,488	3,860	5,285	7,052	6,311	4,440

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 discount applicants.

MANHATTANLIFE INSURANCE AND ANNUITY COMPANY
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN IOWA ZIP CODES
503, 515

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,959	2,270	1,850	1,245	2,253	2,610	2,128	1,433
66	1,959	2,270	1,850	1,245	2,253	2,610	2,128	1,433
67	1,959	2,270	1,850	1,245	2,253	2,610	2,128	1,433
68	2,001	2,311	1,875	1,286	2,302	2,658	2,155	1,479
69	2,071	2,387	1,926	1,324	2,381	2,747	2,214	1,522
70	2,144	2,465	1,980	1,365	2,467	2,835	2,277	1,570
71	2,209	2,545	2,048	1,421	2,540	2,926	2,355	1,636
72	2,273	2,624	2,117	1,480	2,614	3,017	2,434	1,701
73	2,337	2,703	2,189	1,537	2,687	3,109	2,514	1,766
74	2,425	2,809	2,270	1,595	2,788	3,231	2,609	1,835
75	2,526	2,932	2,362	1,661	2,905	3,372	2,718	1,911
76	2,612	3,049	2,449	1,722	3,004	3,506	2,816	1,981
77	2,701	3,172	2,551	1,785	3,106	3,646	2,932	2,053
78	2,796	3,301	2,661	1,848	3,216	3,797	3,060	2,126
79	2,900	3,441	2,785	1,914	3,333	3,958	3,202	2,200
80	3,008	3,591	2,920	1,989	3,460	4,130	3,360	2,287
81	3,114	3,746	3,069	2,097	3,581	4,309	3,531	2,411
82	3,224	3,912	3,231	2,212	3,709	4,499	3,716	2,544
83	3,342	4,089	3,409	2,338	3,844	4,701	3,920	2,689
84	3,468	4,275	3,601	2,474	3,989	4,918	4,142	2,846
85	3,602	4,474	3,810	2,622	4,143	5,146	4,381	3,018
86	3,728	4,666	4,010	2,768	4,288	5,365	4,613	3,185
87	3,865	4,869	4,221	2,922	4,444	5,599	4,855	3,361
88	4,009	5,086	4,435	3,076	4,610	5,849	5,100	3,539
89	4,160	5,316	4,649	3,234	4,786	6,113	5,345	3,718
90	4,304	5,535	4,863	3,392	4,950	6,365	5,593	3,898
91	4,428	5,739	5,064	3,538	5,093	6,598	5,823	4,068
92	4,557	5,950	5,263	3,683	5,240	6,840	6,051	4,236
93	4,672	6,142	5,458	3,826	5,372	7,063	6,276	4,401
94	4,781	6,334	5,650	3,968	5,500	7,285	6,496	4,565
95	4,892	6,527	5,838	4,106	5,626	7,506	6,712	4,721
96	4,995	6,664	5,965	4,197	5,744	7,663	6,859	4,826
97	5,095	6,796	6,083	4,279	5,859	7,816	6,996	4,922
98	5,192	6,927	6,200	4,362	5,971	7,966	7,130	5,016
99	5,285	7,052	6,311	4,440	6,079	8,108	7,257	5,106

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 discount applicants.

MANHATTANLIFE INSURANCE AND ANNUITY COMPANY
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN IOWA ZIP CODES
500-502, 504-514, 516, 520-528

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,479	1,713	1,397	940	1,701	1,970	1,606	1,081
66	1,479	1,713	1,397	940	1,701	1,970	1,606	1,081
67	1,479	1,713	1,397	940	1,701	1,970	1,606	1,081
68	1,510	1,745	1,415	970	1,737	2,007	1,627	1,116
69	1,563	1,803	1,454	999	1,798	2,072	1,672	1,149
70	1,619	1,860	1,495	1,032	1,861	2,140	1,719	1,185
71	1,666	1,921	1,544	1,074	1,918	2,210	1,778	1,234
72	1,715	1,981	1,597	1,117	1,973	2,278	1,838	1,285
73	1,764	2,041	1,651	1,161	2,029	2,346	1,900	1,334
74	1,830	2,120	1,714	1,205	2,105	2,439	1,970	1,385
75	1,907	2,214	1,783	1,255	2,193	2,545	2,051	1,442
76	1,972	2,300	1,849	1,301	2,267	2,647	2,126	1,495
77	2,039	2,394	1,925	1,347	2,345	2,754	2,214	1,550
78	2,112	2,491	2,010	1,396	2,428	2,865	2,310	1,604
79	2,188	2,598	2,101	1,443	2,518	2,987	2,417	1,661
80	2,271	2,709	2,204	1,502	2,611	3,117	2,535	1,727
81	2,350	2,828	2,318	1,582	2,703	3,252	2,665	1,820
82	2,434	2,954	2,441	1,670	2,799	3,396	2,805	1,920
83	2,523	3,087	2,574	1,766	2,902	3,549	2,959	2,030
84	2,618	3,228	2,718	1,868	3,011	3,711	3,126	2,148
85	2,718	3,378	2,876	1,981	3,127	3,884	3,308	2,276
86	2,816	3,523	3,027	2,090	3,237	4,050	3,482	2,403
87	2,917	3,676	3,187	2,206	3,355	4,227	3,664	2,537
88	3,026	3,839	3,347	2,323	3,480	4,415	3,850	2,670
89	3,143	4,013	3,509	2,441	3,611	4,615	4,036	2,808
90	3,248	4,179	3,671	2,560	3,737	4,805	4,222	2,944
91	3,343	4,331	3,823	2,669	3,844	4,983	4,396	3,072
92	3,440	4,490	3,973	2,781	3,956	5,165	4,569	3,197
93	3,526	4,637	4,120	2,889	4,056	5,332	4,738	3,321
94	3,610	4,783	4,265	2,996	4,151	5,498	4,905	3,444
95	3,693	4,926	4,405	3,100	4,247	5,667	5,068	3,564
96	3,771	5,031	4,501	3,168	4,336	5,785	5,178	3,643
97	3,847	5,132	4,592	3,231	4,423	5,900	5,281	3,715
98	3,919	5,228	4,679	3,293	4,508	6,013	5,382	3,786
99	3,990	5,324	4,764	3,351	4,588	6,122	5,479	3,854

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.
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MANHATTANLIFE INSURANCE AND ANNUITY COMPANY
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN IOWA ZIP CODES
500-502, 504-514, 516, 520-528

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
65	1,701	1,970	1,606	1,081	1,956	2,266	1,847	1,244
66	1,701	1,970	1,606	1,081	1,956	2,266	1,847	1,244
67	1,701	1,970	1,606	1,081	1,956	2,266	1,847	1,244
68	1,737	2,007	1,627	1,116	1,999	2,308	1,871	1,284
69	1,798	2,072	1,672	1,149	2,067	2,385	1,922	1,322
70	1,861	2,140	1,719	1,185	2,142	2,461	1,977	1,363
71	1,918	2,210	1,778	1,234	2,205	2,540	2,045	1,420
72	1,973	2,278	1,838	1,285	2,270	2,619	2,113	1,477
73	2,029	2,346	1,900	1,334	2,333	2,699	2,183	1,533
74	2,105	2,439	1,970	1,385	2,421	2,805	2,265	1,593
75	2,193	2,545	2,051	1,442	2,522	2,928	2,360	1,659
76	2,267	2,647	2,126	1,495	2,608	3,044	2,445	1,720
77	2,345	2,754	2,214	1,550	2,696	3,166	2,545	1,782
78	2,428	2,865	2,310	1,604	2,792	3,296	2,657	1,845
79	2,518	2,987	2,417	1,661	2,894	3,436	2,780	1,910
80	2,611	3,117	2,535	1,727	3,004	3,585	2,917	1,985
81	2,703	3,252	2,665	1,820	3,109	3,741	3,065	2,093
82	2,799	3,396	2,805	1,920	3,220	3,906	3,226	2,209
83	2,902	3,549	2,959	2,030	3,337	4,081	3,403	2,334
84	3,011	3,711	3,126	2,148	3,463	4,269	3,596	2,471
85	3,127	3,884	3,308	2,276	3,597	4,467	3,803	2,620
86	3,237	4,050	3,482	2,403	3,722	4,658	4,005	2,765
87	3,355	4,227	3,664	2,537	3,858	4,861	4,215	2,917
88	3,480	4,415	3,850	2,670	4,002	5,077	4,427	3,072
89	3,611	4,615	4,036	2,808	4,155	5,307	4,640	3,228
90	3,737	4,805	4,222	2,944	4,298	5,526	4,855	3,384
91	3,844	4,983	4,396	3,072	4,422	5,728	5,055	3,531
92	3,956	5,165	4,569	3,197	4,549	5,938	5,253	3,677
93	4,056	5,332	4,738	3,321	4,663	6,131	5,449	3,820
94	4,151	5,498	4,905	3,444	4,775	6,324	5,640	3,963
95	4,247	5,667	5,068	3,564	4,884	6,516	5,827	4,099
96	4,336	5,785	5,178	3,643	4,986	6,653	5,954	4,189
97	4,423	5,900	5,281	3,715	5,087	6,785	6,074	4,273
98	4,508	6,013	5,382	3,786	5,183	6,916	6,190	4,354
99	4,588	6,122	5,479	3,854	5,277	7,039	6,300	4,433

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 discount 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 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
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.

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

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

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

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

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

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

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $240 of Medicare Approved Amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare Approved Amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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