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 MISSOURI ZIP CODES
634-639, 642-659

Issue	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	2,277	3,361	2,231	1,723	2,596	3,831	2,543	1,964
65	2,277	2,649	1,949	1,522	2,596	3,020	2,222	1,734
66	2,277	2,649	1,949	1,522	2,596	3,020	2,222	1,734
67	2,277	2,649	1,949	1,522	2,596	3,020	2,222	1,734
68	2,334	2,702	1,959	1,600	2,660	3,080	2,234	1,822
69	2,380	2,767	2,015	1,654	2,714	3,153	2,298	1,887
70	2,428	2,830	2,072	1,711	2,767	3,227	2,363	1,950
71	2,474	2,895	2,129	1,768	2,820	3,299	2,426	2,015
72	2,521	2,959	2,185	1,822	2,873	3,373	2,490	2,078
73	2,601	3,069	2,259	1,866	2,966	3,497	2,575	2,128
74	2,682	3,178	2,333	1,910	3,058	3,623	2,659	2,177
75	2,763	3,288	2,407	1,954	3,150	3,747	2,744	2,228
76	2,843	3,397	2,482	1,998	3,241	3,872	2,829	2,277
77	2,924	3,507	2,556	2,042	3,333	3,996	2,915	2,328
78	2,988	3,629	2,620	2,101	3,406	4,136	2,986	2,395
79	3,053	3,751	2,684	2,160	3,480	4,277	3,059	2,462
80	3,118	3,874	2,746	2,219	3,553	4,417	3,132	2,530
81	3,181	3,996	2,812	2,278	3,626	4,557	3,205	2,598
82	3,245	4,120	2,875	2,338	3,700	4,697	3,279	2,665
83	3,331	4,250	2,951	2,402	3,797	4,847	3,362	2,740
84	3,415	4,383	3,025	2,468	3,892	4,997	3,448	2,814
85	3,498	4,515	3,100	2,534	3,989	5,148	3,533	2,889
86	3,582	4,647	3,175	2,600	4,085	5,298	3,619	2,963
87	3,668	4,778	3,249	2,665	4,180	5,448	3,704	3,039
88	3,754	4,914	3,326	2,732	4,279	5,602	3,791	3,114
89	3,842	5,054	3,405	2,801	4,380	5,761	3,881	3,193
90	3,934	5,197	3,484	2,871	4,484	5,925	3,971	3,274
91	4,025	5,345	3,567	2,944	4,588	6,092	4,066	3,355
92	4,120	5,496	3,650	3,018	4,697	6,266	4,162	3,441
93	4,218	5,652	3,736	3,093	4,807	6,443	4,258	3,527
94	4,316	5,813	3,824	3,172	4,922	6,627	4,359	3,615
95	4,418	5,978	3,914	3,252	5,037	6,815	4,462	3,707
96	4,522	6,148	4,007	3,333	5,155	7,007	4,567	3,801
97	4,629	6,322	4,100	3,417	5,276	7,207	4,675	3,896
98	4,738	6,501	4,198	3,503	5,401	7,411	4,785	3,994
99	4,850	6,685	4,297	3,591	5,529	7,620	4,897	4,095

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

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

A discount factor of .93 is applied for household applicants
There is a one-time $25.00 policy fee.

ManhattanLife Insurance and Annuity Company
Annual Standard Premium Rates
FOR USE IN MISSOURI ZIP CODES
634-639, 642-659

Issue	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	2,618	3,864	2,565	1,982	2,985	4,406	2,924	2,260
65	2,618	3,046	2,242	1,749	2,985	3,473	2,556	1,995
66	2,618	3,046	2,242	1,749	2,985	3,473	2,556	1,995
67	2,618	3,046	2,242	1,749	2,985	3,473	2,556	1,995
68	2,685	3,107	2,252	1,838	3,060	3,542	2,568	2,096
69	2,738	3,182	2,319	1,903	3,121	3,626	2,643	2,170
70	2,790	3,255	2,383	1,969	3,182	3,711	2,716	2,243
71	2,845	3,329	2,448	2,032	3,244	3,795	2,790	2,317
72	2,898	3,402	2,512	2,096	3,304	3,879	2,864	2,390
73	2,991	3,528	2,599	2,147	3,411	4,023	2,961	2,447
74	3,084	3,655	2,684	2,197	3,516	4,166	3,059	2,504
75	3,177	3,780	2,768	2,248	3,621	4,310	3,156	2,563
76	3,269	3,905	2,853	2,297	3,728	4,453	3,253	2,619
77	3,362	4,032	2,939	2,348	3,833	4,596	3,351	2,676
78	3,437	4,173	3,014	2,416	3,918	4,758	3,435	2,754
79	3,511	4,315	3,086	2,484	4,001	4,918	3,518	2,832
80	3,584	4,455	3,159	2,552	4,087	5,079	3,602	2,909
81	3,659	4,596	3,233	2,621	4,170	5,240	3,685	2,987
82	3,732	4,739	3,306	2,688	4,255	5,401	3,770	3,065
83	3,829	4,888	3,392	2,764	4,365	5,574	3,868	3,150
84	3,927	5,041	3,478	2,839	4,477	5,746	3,965	3,236
85	4,024	5,193	3,566	2,914	4,587	5,919	4,064	3,322
86	4,121	5,345	3,650	2,989	4,697	6,092	4,162	3,408
87	4,219	5,496	3,736	3,065	4,807	6,266	4,259	3,494
88	4,318	5,651	3,825	3,142	4,922	6,443	4,360	3,582
89	4,418	5,812	3,914	3,221	5,037	6,626	4,462	3,672
90	4,522	5,977	4,007	3,303	5,157	6,814	4,567	3,764
91	4,629	6,146	4,101	3,385	5,276	7,007	4,675	3,859
92	4,739	6,321	4,198	3,470	5,401	7,205	4,785	3,956
93	4,850	6,501	4,297	3,557	5,529	7,410	4,899	4,055
94	4,964	6,684	4,398	3,648	5,659	7,620	5,013	4,158
95	5,081	6,874	4,501	3,739	5,792	7,836	5,131	4,264
96	5,201	7,069	4,608	3,833	5,929	8,058	5,252	4,370
97	5,323	7,271	4,716	3,930	6,068	8,287	5,376	4,480
98	5,448	7,476	4,827	4,029	6,211	8,523	5,503	4,594
99	5,577	7,689	4,939	4,131	6,358	8,765	5,632	4,709

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

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

A discount factor of .93 is applied for household applicants
There is a one-time $25.00 policy fee.

ManhattanLife Insurance and Annuity Company
Annual Preferred Premium Rates
FOR USE IN MISSOURI ZIP CODES
630-633, 640-641

Issue	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	2,613	3,857	2,560	1,978	2,980	4,397	2,919	2,254
65	2,613	3,040	2,237	1,746	2,980	3,466	2,550	1,991
66	2,613	3,040	2,237	1,746	2,980	3,466	2,550	1,991
67	2,613	3,040	2,237	1,746	2,980	3,466	2,550	1,991
68	2,679	3,102	2,248	1,836	3,053	3,535	2,564	2,092
69	2,732	3,175	2,313	1,899	3,115	3,619	2,637	2,165
70	2,787	3,248	2,378	1,963	3,175	3,704	2,712	2,238
71	2,839	3,323	2,443	2,029	3,237	3,786	2,785	2,313
72	2,894	3,397	2,508	2,092	3,298	3,871	2,857	2,385
73	2,986	3,522	2,593	2,142	3,404	4,014	2,955	2,442
74	3,078	3,647	2,678	2,193	3,510	4,158	3,052	2,499
75	3,171	3,773	2,762	2,242	3,616	4,301	3,149	2,557
76	3,263	3,899	2,848	2,293	3,720	4,444	3,247	2,614
77	3,356	4,025	2,934	2,344	3,826	4,586	3,345	2,671
78	3,430	4,165	3,007	2,411	3,910	4,747	3,427	2,749
79	3,504	4,306	3,081	2,479	3,994	4,909	3,511	2,826
80	3,578	4,446	3,152	2,547	4,078	5,069	3,595	2,904
81	3,651	4,586	3,227	2,615	4,162	5,230	3,678	2,982
82	3,725	4,729	3,300	2,684	4,246	5,390	3,763	3,058
83	3,823	4,878	3,387	2,757	4,358	5,563	3,859	3,145
84	3,920	5,031	3,471	2,833	4,467	5,735	3,957	3,230
85	4,015	5,182	3,558	2,909	4,578	5,909	4,055	3,316
86	4,112	5,334	3,644	2,984	4,688	6,080	4,153	3,401
87	4,210	5,484	3,729	3,058	4,798	6,253	4,251	3,488
88	4,309	5,640	3,818	3,136	4,912	6,430	4,351	3,574
89	4,410	5,800	3,908	3,215	5,027	6,612	4,454	3,664
90	4,515	5,965	3,999	3,296	5,146	6,800	4,558	3,757
91	4,620	6,135	4,094	3,378	5,266	6,992	4,666	3,851
92	4,729	6,307	4,189	3,463	5,390	7,192	4,776	3,949
93	4,841	6,487	4,287	3,550	5,518	7,395	4,887	4,048
94	4,953	6,672	4,389	3,640	5,649	7,606	5,003	4,149
95	5,071	6,861	4,492	3,733	5,781	7,821	5,122	4,254
96	5,190	7,056	4,599	3,826	5,917	8,043	5,242	4,362
97	5,313	7,256	4,706	3,922	6,056	8,272	5,365	4,471
98	5,438	7,462	4,818	4,021	6,199	8,506	5,491	4,584
99	5,566	7,673	4,932	4,122	6,346	8,746	5,621	4,700

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

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

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ManhattanLife Insurance and Annuity Company
Annual Standard Premium Rates
FOR USE IN MISSOURI ZIP CODES
630-633, 640-641

Issue	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	3,005	4,435	2,944	2,275	3,426	5,057	3,356	2,594
65	3,005	3,496	2,573	2,008	3,426	3,986	2,934	2,290
66	3,005	3,496	2,573	2,008	3,426	3,986	2,934	2,290
67	3,005	3,496	2,573	2,008	3,426	3,986	2,934	2,290
68	3,082	3,566	2,585	2,110	3,512	4,065	2,947	2,406
69	3,142	3,652	2,661	2,185	3,582	4,161	3,033	2,491
70	3,203	3,736	2,735	2,259	3,652	4,259	3,117	2,574
71	3,265	3,821	2,810	2,332	3,723	4,355	3,202	2,659
72	3,326	3,905	2,884	2,406	3,793	4,452	3,288	2,743
73	3,433	4,049	2,983	2,464	3,915	4,618	3,399	2,809
74	3,539	4,195	3,081	2,522	4,036	4,781	3,511	2,874
75	3,646	4,338	3,176	2,580	4,156	4,947	3,622	2,941
76	3,752	4,482	3,274	2,636	4,278	5,111	3,734	3,006
77	3,859	4,628	3,373	2,695	4,400	5,275	3,846	3,071
78	3,945	4,789	3,459	2,772	4,497	5,461	3,942	3,160
79	4,030	4,952	3,542	2,851	4,592	5,645	4,038	3,250
80	4,114	5,114	3,626	2,929	4,690	5,830	4,134	3,339
81	4,200	5,275	3,711	3,008	4,786	6,014	4,230	3,428
82	4,283	5,439	3,795	3,086	4,883	6,199	4,327	3,518
83	4,395	5,611	3,894	3,172	5,010	6,397	4,439	3,615
84	4,507	5,785	3,992	3,258	5,138	6,595	4,551	3,714
85	4,619	5,960	4,093	3,344	5,264	6,793	4,664	3,813
86	4,730	6,135	4,189	3,431	5,390	6,992	4,777	3,912
87	4,842	6,307	4,287	3,518	5,518	7,191	4,888	4,010
88	4,956	6,486	4,390	3,606	5,649	7,395	5,004	4,112
89	5,071	6,670	4,492	3,697	5,781	7,605	5,122	4,215
90	5,190	6,860	4,599	3,791	5,919	7,820	5,242	4,320
91	5,313	7,054	4,707	3,885	6,056	8,042	5,365	4,429
92	5,439	7,255	4,818	3,982	6,199	8,270	5,492	4,541
93	5,566	7,461	4,932	4,082	6,346	8,504	5,623	4,654
94	5,697	7,672	5,048	4,186	6,495	8,746	5,754	4,772
95	5,832	7,889	5,166	4,291	6,648	8,994	5,889	4,893
96	5,969	8,113	5,288	4,400	6,804	9,249	6,028	5,016
97	6,109	8,345	5,413	4,511	6,965	9,511	6,170	5,142
98	6,253	8,580	5,540	4,624	7,129	9,782	6,316	5,272
99	6,400	8,824	5,669	4,741	7,297	10,060	6,464	5,405

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

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

A discount factor of .93 is applied for household applicants
There is a one-time $25.00 policy fee.

PREMIUM INFORMATION

We, ManhattanLife Insurance and Annuity Company, can only raise your premium if We raise the premium for all policies like your's in this State.. 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 issue age, underwriting class, and state of residence.

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.

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* 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.