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]						$7,220[2]	$3,610[2]					

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,870 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 OREGON ZIP CODES
970-972

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	2,208	2,336	1,932	1,469	2,428	2,570	2,126	1,616
65	2,208	2,336	1,932	1,469	2,428	2,570	2,126	1,616
66	2,208	2,336	1,932	1,469	2,428	2,570	2,126	1,616
67	2,208	2,336	1,932	1,469	2,428	2,570	2,126	1,616
68	2,256	2,549	2,029	1,553	2,481	2,804	2,230	1,709
69	2,336	2,665	2,127	1,617	2,569	2,931	2,338	1,778
70	2,418	2,772	2,198	1,679	2,660	3,048	2,418	1,847
71	2,490	2,876	2,288	1,749	2,739	3,163	2,517	1,923
72	2,562	2,978	2,378	1,819	2,818	3,276	2,616	2,002
73	2,634	3,089	2,469	1,888	2,898	3,398	2,716	2,079
74	2,733	3,202	2,562	1,959	3,007	3,523	2,818	2,155
75	2,848	3,321	2,668	2,030	3,133	3,653	2,935	2,233
76	2,944	3,425	2,758	2,094	3,238	3,767	3,032	2,304
77	3,045	3,538	2,852	2,172	3,349	3,892	3,138	2,389
78	3,152	3,659	2,955	2,247	3,466	4,025	3,250	2,473
79	3,268	3,780	3,058	2,338	3,595	4,158	3,364	2,572
80	3,392	3,906	3,164	2,432	3,731	4,296	3,480	2,674
81	3,509	4,032	3,271	2,525	3,860	4,435	3,597	2,777
82	3,634	4,162	3,380	2,621	3,999	4,578	3,719	2,883
83	3,767	4,294	3,493	2,706	4,144	4,723	3,843	2,976
84	3,909	4,429	3,608	2,792	4,300	4,873	3,969	3,072
85	4,059	4,544	3,707	2,879	4,465	5,000	4,078	3,166
86	4,202	4,620	3,772	2,937	4,622	5,082	4,148	3,231
87	4,356	4,671	3,817	2,981	4,791	5,139	4,199	3,278
88	4,518	4,723	3,863	3,023	4,970	5,196	4,250	3,326
89	4,691	4,775	3,909	3,067	5,160	5,253	4,299	3,373
90	4,850	4,827	3,955	3,109	5,336	5,310	4,351	3,421
91	4,991	4,867	3,991	3,145	5,490	5,355	4,389	3,459
92	5,135	4,908	4,027	3,179	5,650	5,400	4,429	3,497
93	5,265	4,948	4,063	3,212	5,792	5,443	4,469	3,533
94	5,390	4,991	4,098	3,247	5,930	5,488	4,508	3,571
95	5,514	5,031	4,133	3,281	6,066	5,534	4,548	3,609
96	5,630	5,031	4,133	3,281	6,193	5,534	4,548	3,609
97	5,742	5,031	4,133	3,281	6,317	5,534	4,548	3,609
98	5,852	5,031	4,133	3,281	6,438	5,534	4,548	3,609
99	5,958	5,031	4,133	3,281	6,553	5,534	4,548	3,609

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 OREGON ZIP CODES
970-972

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	2,539	2,687	2,223	1,689	2,793	2,956	2,444	1,859
65	2,539	2,687	2,223	1,689	2,793	2,956	2,444	1,859
66	2,539	2,687	2,223	1,689	2,793	2,956	2,444	1,859
67	2,539	2,687	2,223	1,689	2,793	2,956	2,444	1,859
68	2,595	2,931	2,331	1,787	2,853	3,224	2,565	1,966
69	2,684	3,066	2,446	1,859	2,955	3,371	2,690	2,045
70	2,779	3,187	2,527	1,931	3,058	3,506	2,780	2,123
71	2,863	3,307	2,631	2,012	3,149	3,636	2,893	2,212
72	2,947	3,425	2,734	2,093	3,241	3,767	3,008	2,301
73	3,029	3,552	2,840	2,173	3,332	3,908	3,124	2,390
74	3,144	3,682	2,947	2,253	3,458	4,050	3,241	2,480
75	3,275	3,819	3,068	2,335	3,604	4,201	3,374	2,567
76	3,385	3,938	3,171	2,408	3,723	4,333	3,487	2,650
77	3,500	4,070	3,281	2,497	3,850	4,477	3,609	2,747
78	3,623	4,207	3,398	2,586	3,986	4,627	3,737	2,844
79	3,758	4,347	3,517	2,690	4,133	4,782	3,868	2,958
80	3,901	4,491	3,639	2,797	4,289	4,941	4,002	3,075
81	4,035	4,637	3,761	2,904	4,439	5,100	4,138	3,193
82	4,181	4,785	3,888	3,014	4,596	5,265	4,276	3,315
83	4,333	4,937	4,018	3,111	4,766	5,431	4,419	3,422
84	4,496	5,092	4,149	3,210	4,946	5,603	4,565	3,531
85	4,667	5,226	4,262	3,310	5,135	5,749	4,690	3,641
86	4,834	5,312	4,338	3,378	5,316	5,845	4,770	3,715
87	5,009	5,371	4,389	3,426	5,509	5,909	4,829	3,770
88	5,195	5,431	4,442	3,477	5,714	5,975	4,887	3,825
89	5,395	5,492	4,495	3,526	5,933	6,041	4,945	3,880
90	5,578	5,551	4,548	3,577	6,135	6,107	5,002	3,934
91	5,740	5,598	4,589	3,615	6,314	6,158	5,048	3,978
92	5,906	5,644	4,629	3,655	6,497	6,210	5,092	4,020
93	6,054	5,692	4,671	3,694	6,658	6,261	5,139	4,064
94	6,199	5,738	4,712	3,733	6,819	6,312	5,183	4,107
95	6,341	5,785	4,753	3,773	6,976	6,364	5,229	4,150
96	6,474	5,785	4,753	3,773	7,123	6,364	5,229	4,150
97	6,604	5,785	4,753	3,773	7,264	6,364	5,229	4,150
98	6,731	5,785	4,753	3,773	7,402	6,364	5,229	4,150
99	6,851	5,785	4,753	3,773	7,537	6,364	5,229	4,150

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 OREGON ZIP CODES
973-979

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	2,085	2,207	1,825	1,387	2,293	2,427	2,008	1,526
65	2,085	2,207	1,825	1,387	2,293	2,427	2,008	1,526
66	2,085	2,207	1,825	1,387	2,293	2,427	2,008	1,526
67	2,085	2,207	1,825	1,387	2,293	2,427	2,008	1,526
68	2,131	2,407	1,916	1,467	2,343	2,648	2,106	1,614
69	2,206	2,517	2,009	1,527	2,426	2,768	2,208	1,679
70	2,284	2,618	2,076	1,585	2,512	2,879	2,284	1,744
71	2,352	2,716	2,161	1,652	2,587	2,987	2,377	1,816
72	2,420	2,813	2,246	1,718	2,661	3,094	2,471	1,890
73	2,488	2,917	2,332	1,783	2,737	3,210	2,565	1,964
74	2,581	3,024	2,420	1,850	2,840	3,327	2,661	2,035
75	2,689	3,137	2,519	1,917	2,959	3,450	2,772	2,109
76	2,780	3,235	2,604	1,978	3,058	3,558	2,864	2,176
77	2,876	3,341	2,694	2,051	3,163	3,675	2,964	2,256
78	2,977	3,455	2,791	2,122	3,273	3,801	3,069	2,336
79	3,086	3,570	2,888	2,208	3,395	3,927	3,177	2,429
80	3,204	3,689	2,988	2,297	3,523	4,057	3,287	2,525
81	3,314	3,808	3,089	2,384	3,646	4,189	3,397	2,623
82	3,432	3,930	3,193	2,475	3,777	4,324	3,512	2,723
83	3,557	4,055	3,299	2,556	3,913	4,461	3,630	2,811
84	3,692	4,183	3,408	2,637	4,061	4,602	3,749	2,901
85	3,834	4,292	3,501	2,719	4,217	4,722	3,851	2,990
86	3,969	4,363	3,562	2,774	4,366	4,800	3,918	3,052
87	4,114	4,412	3,605	2,815	4,525	4,854	3,966	3,096
88	4,267	4,461	3,648	2,855	4,694	4,907	4,014	3,141
89	4,430	4,510	3,692	2,897	4,873	4,961	4,060	3,186
90	4,581	4,559	3,735	2,936	5,040	5,015	4,109	3,231
91	4,714	4,597	3,769	2,970	5,185	5,058	4,145	3,267
92	4,850	4,635	3,803	3,002	5,336	5,100	4,183	3,302
93	4,973	4,673	3,837	3,034	5,470	5,141	4,220	3,336
94	5,091	4,713	3,870	3,067	5,601	5,183	4,258	3,373
95	5,208	4,752	3,903	3,099	5,729	5,227	4,295	3,409
96	5,317	4,752	3,903	3,099	5,849	5,227	4,295	3,409
97	5,423	4,752	3,903	3,099	5,966	5,227	4,295	3,409
98	5,527	4,752	3,903	3,099	6,080	5,227	4,295	3,409
99	5,627	4,752	3,903	3,099	6,189	5,227	4,295	3,409

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 OREGON ZIP CODES
973-979

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	2,398	2,537	2,100	1,595	2,638	2,791	2,309	1,755
65	2,398	2,537	2,100	1,595	2,638	2,791	2,309	1,755
66	2,398	2,537	2,100	1,595	2,638	2,791	2,309	1,755
67	2,398	2,537	2,100	1,595	2,638	2,791	2,309	1,755
68	2,451	2,768	2,202	1,688	2,695	3,045	2,423	1,856
69	2,535	2,896	2,310	1,756	2,791	3,184	2,541	1,931
70	2,625	3,010	2,387	1,823	2,888	3,312	2,626	2,005
71	2,704	3,123	2,485	1,900	2,974	3,434	2,732	2,089
72	2,783	3,235	2,582	1,976	3,061	3,558	2,841	2,173
73	2,860	3,355	2,683	2,052	3,147	3,691	2,950	2,257
74	2,969	3,477	2,783	2,128	3,266	3,825	3,061	2,342
75	3,093	3,607	2,898	2,205	3,403	3,968	3,187	2,424
76	3,197	3,720	2,995	2,275	3,516	4,092	3,293	2,502
77	3,306	3,844	3,099	2,358	3,636	4,228	3,409	2,594
78	3,422	3,973	3,209	2,442	3,765	4,370	3,529	2,686
79	3,550	4,106	3,322	2,541	3,903	4,516	3,653	2,794
80	3,684	4,242	3,437	2,642	4,051	4,667	3,780	2,904
81	3,811	4,379	3,552	2,743	4,192	4,817	3,908	3,016
82	3,948	4,519	3,672	2,847	4,341	4,973	4,038	3,131
83	4,092	4,663	3,794	2,938	4,501	5,129	4,174	3,232
84	4,246	4,809	3,919	3,032	4,671	5,292	4,311	3,335
85	4,408	4,936	4,026	3,126	4,850	5,430	4,429	3,439
86	4,565	5,017	4,097	3,190	5,021	5,520	4,505	3,509
87	4,730	5,073	4,145	3,236	5,203	5,581	4,561	3,561
88	4,906	5,129	4,196	3,284	5,397	5,643	4,616	3,613
89	5,095	5,187	4,245	3,330	5,603	5,705	4,670	3,664
90	5,268	5,243	4,295	3,378	5,794	5,767	4,724	3,715
91	5,421	5,287	4,334	3,414	5,964	5,816	4,768	3,757
92	5,578	5,330	4,372	3,452	6,136	5,865	4,809	3,797
93	5,718	5,375	4,412	3,488	6,288	5,913	4,854	3,838
94	5,855	5,419	4,451	3,526	6,440	5,961	4,895	3,879
95	5,989	5,464	4,489	3,563	6,588	6,010	4,939	3,919
96	6,114	5,464	4,489	3,563	6,727	6,010	4,939	3,919
97	6,237	5,464	4,489	3,563	6,860	6,010	4,939	3,919
98	6,357	5,464	4,489	3,563	6,990	6,010	4,939	3,919
99	6,470	5,464	4,489	3,563	7,118	6,010	4,939	3,919

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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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 $1676	$0	$1676 (Part A deductible)
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	$0	Up to $209.50 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 $257 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 $257 of Medicare Approved Amounts*	$0	$0	$257 (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 $257 of Medicare Approved Amounts*	$0	$0	$257 (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 $257 of Medicare Approved Amounts*	$0	$0	$257 (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 $1676	$1676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 $257 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 $257 of Medicare Approved Amounts*	$0	$257 (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 $257 of Medicare Approved amounts*	$0	$257 (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 $257 of Medicare Approved Amounts*	$0	$257 (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 $1676	$1676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 $257 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 $257 of Medicare Approved Amounts*	$0	$0	$257 (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 $257 of Medicare Approved Amounts*	$0	$0	$257 (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 $257 of Medicare Approved Amounts*	$0	$0	$257 (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 $1676	$1676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 $257 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 $257 of Medicare Approved Amounts*	$0	$0	$257 (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 $257 of Medicare Approved Amounts*	$0	$0	$257 (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 $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $257 (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.