THE MANHATTAN LIFE
INSURANCE COMPANY SM

2013 Medicare Supplement

This brochure is for solicitation of insurance and contact will be made by an insurance agent or insurance company.

ML-MEDSUP 0813

Underwritten by The Manhattan Life Insurance Company.

Manhattan Life - Medicare Supplement

Protection From the Bills Medicare Doesn't Pay

Medicare was never meant to cover all of your doctor and hospital bills. Many people do not realize this and expect it to pay all. Reliance on Medicare in this situation can mean financial difficulty with out-of-pocket expenses.

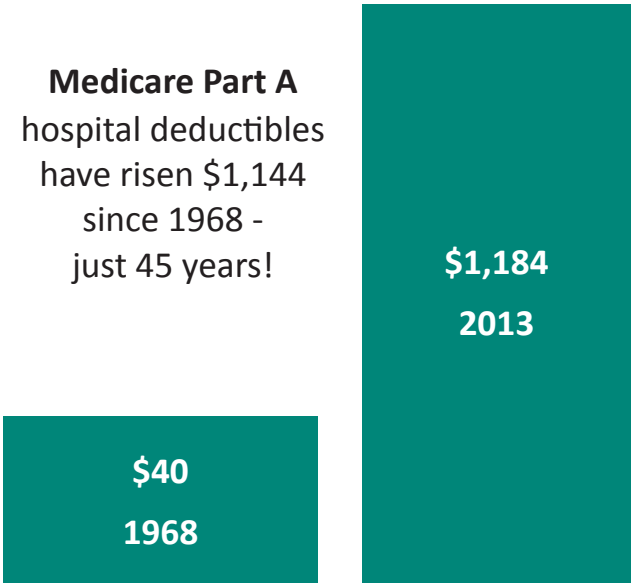
Manhattan Life Offers 8* Standardized Insurance Plans

The Manhattan Life Insurance Company Plans are designed to give you choices - choices you need to help cover health care costs today! Our Plans allow you to choose a Medicare Supplement Plan to suit your life's situation, budget and needs. All Plans may not be available in all states.

**All plans may not be available in your state. Please refer to the Outline of Coverage your agent provided.*

Initial Hospital Deductible

Medicare Part A hospital deductibles have risen $1,144 since 1968 - just 45 years!



All Medicare Supplement Plans Offer These Benefits:

Part A Coinsurance pays if you are confined to a hospital. Should you require more than 60 continuous days hospitalization, Manhattan Life will pay the coinsurance amounts up to the 150th** day of confinement and also for the first 3 pints of blood each year. Additionally, if you use your lifetime reserve days, Manhattan Life will provide coverage for up to an additional 365 days.

Part B Coinsurance pays the Medicare Part B coinsurance amount, reducing your out-of-pocket expenses when you require medical services. Plan N requires a co-payment of up to $20 for an office visit, and up to $50 co-payment for the emergency room.

***Assumes Emergency Reserve days and/or additional 365 days remain.*

THE MANHATTAN LIFE INSURANCE COMPANY SM

ML-MEDSUP 0813

Your Manhattan Life Benefits

Medicare Part A Hospital Coverage

Deductible - Manhattan Life Plans B, C, D, F, G and N all pay the $1,184 inpatient hospital deductible for each benefit period. Plan M pays 50% of the Part A Deductible.

First 60 Days - After the Part A deductible, Medicare pays all eligible expenses for services from your 1st through 60th day of hospital confinement. Services include semi-private room and board, general nursing and miscellaneous hospital services and supplies.

Coinsurance - All Manhattan Life Plans pay up to $296 a day when you're hospitalized from the 61st through the 90th day. And when you're in the hospital from the 91st through 150th day, Manhattan Life Plans pay you up to $592 a day for each Lifetime Reserve day used.

Extended Hospital Coverage - When you're in the hospital longer than 150 days during a Benefit Period, and you've exhausted your 60 Medicare Lifetime Reserve days, all Manhattan Life Plans pay the Part A Medicare eligible expenses for hospitalization, paid at the Prospective Payment System (PPS) rate or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days.

Benefit for Blood - Medicare has one calendar year deductible for blood that is the cost of the first three pints needed. All Manhattan Life Plans pay this deductible.

Skilled Nursing Facility Care

First 20 Days - Medicare pays all eligible expenses.

Coinsurance - Manhattan Life Plans C, D, F, G, M and N pay up to $148 a day from the 21st through the 100th day during which you receive skilled nursing care. You must enter a Medicare-certified skilled nursing facility within 30 days of being hospitalized for at least three days.

Hospice Care - After you meet Medicare's requirements, including a doctor's certification of terminal illness, Medicare pays all but very limited co-payment or coinsurance for outpatient drugs and inpatient respite care. Manhattan Life Plans pay the Medicare co-payment or coinsurance.

Medicare Part B Physician's Services and Supplies

Deductible - Manhattan Life Plans C and F pay the $147 calendar year deductible.

Coinsurance - After the Part B deductible, all Manhattan Life Plans generally pay 20% of Medicare eligible expenses for physician's services, hospital outpatient services and supplies, physical and speech therapy, and ambulance service. Plan N requires the insured to pay a portion of Part B coinsurance or co-payments: up to $20 co-payment for each covered office visit, including specialists, and up to $50 co-payment for each covered Emergency Room (ER) visit. The ER co-payment will be waived if admitted to any Hospital and the ER visit is covered as a Part A Expense.

Excess Benefits - Your bill for Part B services and supplies may exceed the Medicare Eligible Expense. When that occurs, Manhattan Life Plan F and G pay 100% of the difference, up to the charge limitation established by Medicare.

Benefit for Blood - Medicare has one calendar year deductible for blood that is the cost of the first three pints needed. All Manhattan Life Plans pay this deductible.

Additional Benefits

Emergency Care Received Outside the U.S. - After you pay a $250 calendar year deductible, Manhattan Life Plans C, D, F, G, M and N pay you 80% of eligible billed expenses incurred for emergency care that began during the first 60 consecutive days of each trip outside the U.S., that would have otherwise have been covered by Medicare if provided in the U.S., up to a lifetime maximum of $50,000. Benefits are payable for emergency health care you need immediately because of a covered injury or illness of sudden and unexpected onset.

Your Plan - The Facts

Manhattan Life helps pay some eligible expenses not paid for by Medicare Part A and Medicare Part B. ***There may be charges above what Medicare and Manhattan Life pay.***

Medicare Part A eligible expenses for hospital/ skilled nursing facility care include expenses for semi-private room and board, general nursing, miscellaneous services and supplies.

Medicare Part B eligible expenses for medical services include expenses for physician's services, hospital outpatient services and supplies, physical and speech therapy, and ambulance service.

Medicare eligible expenses means expenses of the kind covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

A benefit period begins the first full day you are hospitalized and ends when you have not been in a hospital or skilled nursing facility for 60 days in a row.

Coinsurance is the portion of the Medicare eligible expense you have to pay. It does not include Part A and B deductible amounts not paid by Medicare.

As Medicare deductibles and coinsurance increase, your Manhattan Life benefits will automatically increase. Manhattan Life benefits will not duplicate benefits paid by Medicare.

Benefits are paid to you or to your hospital or doctor.

You have 31 days from your renewal date to pay your premium. Your policy will stay in force during this 31 day grace period.

Your policy is guaranteed renewable. Your policy cannot be cancelled. It will be renewed as long as the premiums are paid on time.

Premium rate adjustments may be made based on current health care cost experience for benefits paid. Manhattan Life reserves the right to establish new premium rates for all insureds based on a class basis, but only after giving you advance notice. ***However, we will not increase premiums based on your own claims. Rates may be based on your age*** and premiums may increase automatically on each policy anniversary date, based on the age you attain*.

You're covered immediately. There is no waiting period for pre-existing conditions. Benefits will be paid from the time your policy is in force.

Manhattan Life Medicare Supplement Plans will not pay for:

- Expenses incurred while the policy is not in force except as provided in the Extension of Benefits section;
- Hospital or skilled nursing facility confinement incurred during a Medicare Part A benefit period that begins while the policy is not in force;
- That portion of any expense incurred which is paid for by Medicare;
- Services for non-Medicare eligible expenses including, but not limited to, routine exams, take-home drugs and eye refractions;
- Services for which a charge is not normally made in the absence of insurance; or
- Loss or expense that is payable under any other Medicare Supplement insurance policy or certificate.

THIS IS A BRIEF DESCRIPTION of your coverage. For complete information on benefits, exceptions and limitations, ***PLEASE READ YOUR ACCOMPANYING OUTLINE OF COVERAGE.***

Neither Manhattan Life nor its agents are connected in any way with the federal or state government or Medicare.

**States that will not increase based on age: AZ, GA, ID*

Notes

Notes

Medicare Plans*

	Medicare Pays	Plan A Pays	Plan B Pays	Plan C Pays	Plan D Pays	Plan F Pays	Plan G Pays	Plan M Pays	Plan N Pays
Medicare Part A Hospital Coverage									
Deductible	All but $1,184	--	$1,184	$1,184	$1,184	$1,184	$1,184	50% of Deductible	$1,184
First 60 days	100%	--	--	--	--	--	--	--	--
Coinsurance 61-90 days	All but $296	Up to $296	Up to $296	Up to $296	Up to $296	Up to $296	Up to $296	Up to $296	Up to $296
Coinsurance 91-150 days	All but $592	Up to $592	Up to $592	Up to $592	Up to $592	Up to $592	Up to $592	Up to $592	Up to $592
Extended Hospital Coverage (up to an additional 365 days in your lifetime)	--	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses	Eligible Expenses
Benefit for Blood First Three Pints	$0	Three Pints	Three Pints	Three Pints	Three Pints	Three Pints	Three Pints	Three Pints	Three Pints
Additional Amounts	100%	--	--	--	--	--	--	--	--
Hospice Care	All but very limited co-payment/ coinsurance for outpatient drugs & inpatient respite care	Medicare co-payment/ coinsurance	Medicare co-payment/ coinsurance	Medicare co-payment/ coinsurance	Medicare co-payment/ coinsurance	Medicare co-payment/ coinsurance	Medicare co-payment/ coinsurance	Medicare co-payment/ coinsurance	Medicare co-payment/ coinsurance
Skilled Nursing Facility Care									
First 20 Days	100%	--	--	--	--	--	--	--	--
Coinsurance 21 - 100 Days	All but $148 a day	--	--	Up to $148	Up to $148	Up to $148	Up to $148	Up to $148	Up to $148
Medicare Part B Physician Services and Supplies									
Deductible	--	--	--	$147	--	$147	--	--	--
Coinsurance	Generally 80%	Generally 20%	Generally 20%	Generally 20%	Generally 20%	Generally 20%	Generally 20%	Generally 20%	Up to $20 co-payment for office visit Up to $50co-payment for ER
Excess Benefits	--	--	--	--	--	100% up to Medicare's Limit	100% up to Medicare's Limit	--	--
Benefit for Blood First Three Pints	$0	Three pints	Three Pints	Three Pints	Three Pints	Three Pints	Three Pints	Three Pints	Three Pints
Additional Amounts	100%	--	--	--	--	--	--	--	--
Additional Benefits									
Emergency Care Received Outside the U.S.	--	--	--	Up to $50,000	Up to $50,000	Up to $50,000	Up to $50,000	Up to $50,000	Up to $50,000

*All plans may not be available in your state. Please refer to the Outline of Coverage your agent provided.

Manhattan Life

Medicare Supplement Plans

For Claims, Please Call:

1-800-877-7703

This brochure is an illustration, not a contract. Consult your Outline of Coverage for a complete description of benefits available to you.

RECEIPT

Received from _____

this _____ day of _____ the sum of $_____

being the payment of _____Premium.

This insurance applied for shall not take effect until the effective date of the policy and the payment of the first premium. In the event the application is declined, any payments made by the applicant will be returned.

_____

Agent's Signature

Make checks payable to The Manhattan Life Insurance Company. Do not make payable to agent or leave payee blank.

Underwritten by:
The Manhattan Life Insurance Company

10777 Northwest Freeway, Suite 600
Houston, Texas 77092

1-800-877-7703

ML-MEDSUP 0813

THE MANHATTAN LIFE INSURANCE COMPANY

Home Office: Houston, TX **Medicare Supplement Administrative Office: P. O. Box 925568, Houston, TX 77292-5568**

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

APPLICANT	**RESIDENCE ADDRESS**
Last *First* *MI*	*Street:*
Check the Medicare Supplement Plan You Prefer:	*City:*
☐ **Plan A** ☐ **Plan F**	
☐ **Plan B** ☐ **Plan G**	
☐ **Plan C** ☐ **Plan M**	*State:* *Zip Code:*
☐ **Plan D** ☐ **Plan N**	

MEDICARE INFORMATION	**MAILING ADDRESS**
Date first enrolled in Medicare Part A:_____	*Street:*
Date first enrolled in Medicare Part B:_____	*City:*
Medicare Claim Number: _____	
(Please include Alpha Character)	*State:* *Zip Code:*

AGE	**DATE OF BIRTH**			**SEX**
	Month	*Day*	*Year*	☐ Male ☐ Female
SOCIAL SECURITY NUMBER				

AREA CODE	**TELEPHONE NUMBER**

(You do not have to answer the height and weight questions during open enrollment or a guaranteed issue period.)

HEIGHT	**WEIGHT**
Feet **Inches**	**Lbs.**

Effective Date:	***Special Requests:***

UNDERWRITING RISK CLASSIFICATION QUESTION	**MODAL PREMIUM:** **$** _____
Have you used any form of tobacco in the past five years?	**HOUSEHOLD DISCOUNT $** _____
☐ Yes ☐ No	**POLICY FEE:** **$** **25.00**
	TOTAL INITIAL PREMIUM: _____

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

☐ Bank Draft ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly Bank Draft

PART I – HEALTH QUESTIONS

YOU ARE NOT REQUIRED TO ANSWER HEALTH QUESTIONS 1-15 IF YOU ARE IN OPEN ENROLLMENT OR A GUARANTEED ISSUE PERIOD.

IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS 1-15, YOU MAY NOT BE ELIGIBLE FOR COVERAGE.

1.	Are you bedridden or confined to a wheelchair or require the assistance of a motorized mobility aid; or in the past two years have you suffered two or more falls within a six month period?	☐ Yes	☐ No
2.	Are you currently hospitalized or confined to a nursing facility; or have you been hospitalized two or more times within the past year?	☐ Yes	☐ No
3.	Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	☐ Yes	☐ No
4.	Is surgery, including cataracts, anticipated in the next twelve months?	☐ Yes	☐ No
5.	Within the past two years have you had an amputation caused by disease?	☐ Yes	☐ No

PART I – HEALTH QUESTIONS CONTINUED

6.	During the past five years have you been advised to have or are you currently having treatment, surgery or medication for any of the following:		
	a. Parkinson's Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Muscular Dystrophy, Alzheimer's Disease, Schizophrenia, Bipolar Disorder, Manic Depression or any other cognitive disorder?	☐ Yes	☐ No
	b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human immunodeficiency virus (HIV) infection?	☐ Yes	☐ No
	c. Diabetes that has required more than 50 units of insulin daily or more than two medications (insulin or oral), Chronic Kidney Disease or Insufficiency, or Renal Failure requiring dialysis?	☐ Yes	☐ No
	d. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Sleep Apnea or any Chronic Pulmonary condition?	☐ Yes	☐ No
	Do you currently require the use of oxygen?	☐ Yes	☐ No
	e. Internal Cancer (examples include but are not limited to breast, lung or liver cancer etc…), Leukemia, Malignant Melanoma, Hodgkin's Disease, or Lymphoma?	☐ Yes	☐ No
	f. Congestive Heart Failure (CHF) or enlarged heart, heart attack, Heart, Coronary or Carotid Artery Disease (not including high blood pressure), Peripheral Vascular Disease, Stroke or Transient Ischemic Attack (TIA) or had a defibrillation device surgically implanted?	☐ Yes	☐ No
7.	Within the past two years have you had atrial fibrillation, any heart rhythm disorder, heart valve surgery, cardiac pacemaker replaced or implanted, or been treated with a heart defibrillating device?	☐ Yes	☐ No
8.	Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Cirrhosis of the Liver, Hepatitis, Alcohol or Drug Abuse, or Systemic Lupus?	☐ Yes	☐ No
9.	Have you had an organ transplant or been advised to have an organ transplant?	☐ Yes	☐ No
10.	Are you currently using the services of a home health care agency?	☐ Yes	☐ No
11.	Do you require or receive any assistance with any of your activities of daily living such as transferring, bathing, toileting, eating, dressing, or continence?	☐ Yes	☐ No
12.	Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Disabling Arthritis, Paget's Disease of the bone, or Rheumatoid Arthritis?	☐ Yes	☐ No
13.	Do you now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for Osteoporosis with fracture or Spinal Stenosis?	☐ Yes	☐ No
14.	Are you diabetic?	☐ Yes	☐ No
	If so do you have or have you been treated for any of the following conditions: diabetic retinopathy, peripheral vascular disease, kidney disease, kidney failure, neuropathy, stroke, congestive heart failure, heart condition, or high blood pressure treated with more than two medications?	☐ Yes	☐ No
15.	Have you had a surgical procedure performed within the last 6 months?		
	If Yes, provide details: _____	☐ Yes	☐ No

Have you taken any prescription medications within the last 24 months? If so, please list all medication(s) you have taken or are currently taking. Attach an additional sheet if necessary. *Please **DO NOT** list water pill, water retention, fluid retention or blood thinner as these are not medical conditions and will require a telephone interview. ☐ Yes ☐ No

Prescription Medication Name	Date Originally Prescribed	Frequency and Dosage	*Diagnosis/Onset Date

Primary Physician Information	**Telephone Number:**
Physician's Address:	
Date of Last Physician's Visit:	
Reason for Visit:	

Did you turn age 65 in the last 6 months? ☐ Yes ☐ No

Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No If yes, what is the effective date? _____

PART II – MEDICAL COVERAGE REPLACEMENT (MUST BE COMPLETED)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement policy, or that you had certain rights to buy such a policy you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with our application.

ALL QUESTIONS MUST BE ANSWERED. Please Mark Yes or No with an "X."

To the best of your knowledge:

1. Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No

   NOTE TO APPLICANT: If you are participating in a "Spend-Down" program and have not met your "Share of Cost," please answer NO to this question and proceed to Question 2.

   IF YES,

   (a) Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No

   (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? ☐ Yes ☐ No

2. (a) If you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates. START __/__/__ END __/__/__

   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ Yes ☐ No

   (c) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No

   (d) Did you drop a Medicare Supplement plan to enroll in the Medicare plan? ☐ Yes ☐ No

3. (a) Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No

   (b) If so, with which company: _____

   with which plan: _____

   and what paid-to-date do you have? _____

   (c) If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Yes ☐ No

4. Have you had any other health insurance coverage within the past 63 days (for example, an employer welfare benefit plan, union, or individual plan)? ☐ Yes ☐ No

   (a) If yes, was the plan primary or secondary to Medicare? _____

   (b) Please list the plan name and reason for termination. _____

   _____

   (c) Please list the plan dates of coverage. START __/__/__ END __/__/__

   (d) Do you intend to replace the above mentioned plan with this policy? ☐ Yes ☐ No

   (e) If you qualify for Guaranteed Issue, under what situation do you qualify? _____

IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT

(1) You do not need more than one Medicare Supplement Insurance Policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing your employer or union based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Initials of Proposed Insured:_____ Date:_____

OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

Open Enrollment: You are eligible for Open Enrollment and will not need to answer Health Questions 1-15 on Pages 1 and 2 of this application if (a) you are within six months of purchasing Medicare Part B coverage for the first time; or (b) you were eligible for early Medicare, and you are within six months of turning age 65.

Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997: The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

(a) Enrolled under an employee welfare benefit plan that either: (1) supplements Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits; or (2) is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan; or

(b) Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

(c) Enrolled in a Medicare, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

(d) Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency or other involuntary termination of coverage under the policy, substantial violation of a material policy provision, or material misrepresentation; or

(e) Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage plan, a cost contract, a Medicare Select plan, or a PACE provider, and then the insured person terminates coverage within 12 months of enrollment; or

(f) Upon *first* becoming enrolled in Medicare Part B for benefits at age 65 or older , you enrolled in a Medicare Advantage plan under Part C or PACE provider and then you disenroll within 12 months; or

(g) Enrolled in Medicare Part D plan during the initial open enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare Supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare Supplement policy and submits evidence of enrollment in Medicare Part D along with the application for this policy; or

(h) Lost eligibility for health benefits under Medicaid.

Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.

AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, MIB, Inc. (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person including Medicare, that has any records or knowledge of me or my health or having any non-medical information concerning me to give The Manhattan Life Insurance Company, or its reinsurers, any such information. All information used or disclosed pursuant to authorization may be subject to redisclosure by the recipient and may no longer be protected. I understand that I am authorizing The Manhattan Life Insurance Company to receive my health information, prescription drug usage history and my non-medical information. I understand that prescription drug usage may be used to verify the presence of certain medical conditions and that such history will not be used to decline coverage. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. The released information received by The Manhattan Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Medical information will not be used to decline coverage if you are applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with The Manhattan Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to The Manhattan Life Insurance Company *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying The Manhattan Life Insurance Company in writing at their Medicare Supplement Administrative Office: P.O. Box 925568, Houston, Texas 77292-5568. I understand that such revocation will not have any effect on actions The Manhattan Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and/or denial of insurance benefits.

I acknowledge receiving: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed At: _____ Dated: _____
(City /State) (Month/Day/Year)

Applicant's (or Authorized Representative's) Signature: _____

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or had read to the Applicant, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy sold to the Applicant that is still in force.

_____
_____
_____
_____

2. List any other health insurance policy sold to the Applicant in the past five (5) years that is no longer in force.

_____
_____
_____
_____

I certify that:

1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for and a Guide To Health Insurance for People With Medicare to the Applicant.

Agent's Signature: **Date:**

Agent's Printed Name: **Agent No.:** **In the State of:**

Agent Email Address: **Agent Telephone Number:**

EMAIL CONSENT AUTHORIZATION

❒ I give my written consent to allow the Company to communicate with me by email to the address(es) listed below. I confirm that I have authorization to provide consent for email to the email address(es) that I provide below and further agree to indemnify and hold harmless the Company for any action or loss arising from any incorrect or false email address(es) provided below. I acknowledge that, should I desire to revoke this written authorization, I will inform the Company, in writing, of such revocation.

❒ I decline to give consent to the Company to communicate with me by email. (Do not provide email addresses below)

Primary email address:_____

Secondary email address: _____

Signature:_____ Date: _____

Note: The applicant electing to allow for notices and communications to be sent to the electronic mail address provided by the policyholder should be aware that the insurer rightfully considers this election to be consent by the applicant that all notices may be sent electronically, including notice of non-renewal and notice of cancellation. Therefore the applicant should be diligent in updating the electronic mail address provided to the insurer in the event that the address should change.

AUTHORIZATION

IN FAVOR OF: **Manhattan Life Insurance Company**
Administrative office: **P.O. Box 925568, Houston, Texas 77292-5568**

Name of Bank Customer: _____
Insured's Name: _____
Account Number : _____ **Routing Number:** _____

Requested draft date:
_____
(Must be 1st-28th Only)
☐ **Checking**
☐ **Savings**

To (Name of Bank): _____

Address of Bank: _____

You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Company indicated above, (hereinafter referred to as THE COMPANY), on my account by and payable to the order of The Company for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Company shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by The Company. I further agree that if any such checks or other orders drawn by The Company be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor may result in forfeiture of insurance subject to the policy's 31-day grace period.

Date	**Signature of Depositor**

I am aware that if my application is approved, my initial premium will be drafted upon approval.

Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.

AUTHORIZATION

To: **The Bank above**

In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor may result in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

(Attach Voided Check) **AUTHORITY TO HONOR PREMIUM CHECKS**

The Manhattan Life Insurance Company

Medicare Supplement
Household Discount Form

Applicant name:	Applicant Social Security Number:

I, _____ certify that I meet one of the following requirements for the Household
(Applicant)
Discount.

Please check a box below:

☐ The applicant is married and residing with their spouse

☐ The applicant has been residing for at least the past 12 months with someone who is 60 years or older

Date of Marriage:

Does the Household resident currently have/or are they applying for a Family Life or Manhattan Life Medicare Supplement policy:
☐ YES ☐ NO If YES, please provide a Policy number.

Policy Number:

Household resident name:

Address:	City:	State:	Zip Code:

Social Security Number:	Birthday:

Relationship to Applicant:

Agent/Applicant Signature:

By signing this form I acknowledge all the information is true.

_____

Agent Signature Date

_____

Applicant Signature Date

Manhattan Life Insurance Company
10777 Northwest Freeway
Houston, Texas 77092

Toll Free: 1-800-877-7703
www.manhattanlife.com
Fax: 713-583-2738

THE MANHATTAN LIFE INSURANCE COMPANY SM

THE MANHATTAN LIFE INSURANCE COMPANY

MANHATTAN LIFE INSURANCE COMPANY

Home Office: Houston, Texas
Administrative Office: P. O. Box 924408 Houston, Texas 77292-4408

Notice To Applicant Regarding
REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Manhattan Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY AGENT:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reasons:

- ❒ Additional benefits.
- ❒ No change in benefits, but lower premiums.
- ❒ Fewer benefits and lower premiums.
- ❒ Change in benefits. (Gaining additional benefit(s) but losing some existing benefit(s)).
- ❒ My plan has outpatient drug coverage and I am enrolling in Part D.
- ❒ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. _____
- ❒ Other (please specify) _____

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
Signature of Agent, Broker or Other Representative

_____
Typed Name and Address of Agent

The above **"Notice to Applicant"** was delivered to me on:

_____ _____
Applicant's Signature Date

THE MANHATTAN LIFE INSURANCE COMPANY
Outline of Medicare Supplement Coverage-Cover Page
Benefit Plans A, B, C, D, F, G, M, AND N

These charts show 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. The Manhattan Life Insurance Company offers eight of the eleven plans available.

Plans E, H, I, and J are no longer available for sale.

Basic Benefits:
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or co-payments.
Blood: First three pints of blood each year.
Hospice: Part A coinsurance

A	B	C	D	F	F*	G	K	L	M	N
Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance*		Basic Benefits, including 100% Part B coinsurance	Hospitalization and preventative care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventative care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit $4620; paid at 100% after limit reached	Out-of-pocket limit $2310; paid at 100% after limit reached		

***Plans F also have an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2000 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare Deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN TEXAS ZIP CODES
770-773, 775

Attained	Female								Male							
Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	3,617	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4,015	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	1,347	1,449	1,725	1,490	1,717	1,497	1,452	1,182	1,495	1,609	1,915	1,655	1,906	1,662	1,612	1,313
66	1,347	1,449	1,725	1,490	1,717	1,497	1,452	1,182	1,495	1,609	1,915	1,655	1,906	1,662	1,612	1,313
67	1,347	1,449	1,725	1,490	1,717	1,497	1,452	1,182	1,495	1,609	1,915	1,655	1,906	1,662	1,612	1,313
68	1,408	1,515	1,803	1,567	1,794	1,574	1,527	1,243	1,563	1,681	2,001	1,740	1,992	1,748	1,695	1,380
69	1,464	1,576	1,875	1,640	1,865	1,646	1,596	1,301	1,625	1,748	2,082	1,819	2,071	1,827	1,772	1,443
70	1,523	1,638	1,950	1,714	1,940	1,720	1,669	1,359	1,691	1,818	2,164	1,902	2,154	1,910	1,853	1,509
71	1,584	1,703	2,027	1,791	2,018	1,799	1,745	1,420	1,757	1,891	2,251	1,988	2,240	1,996	1,937	1,577
72	1,647	1,772	2,109	1,871	2,099	1,879	1,823	1,485	1,827	1,967	2,341	2,077	2,330	2,086	2,023	1,648
73	1,696	1,825	2,172	1,934	2,162	1,942	1,884	1,534	1,883	2,025	2,412	2,147	2,399	2,155	2,091	1,703
74	1,747	1,879	2,238	1,999	2,226	2,007	1,947	1,586	1,939	2,086	2,484	2,218	2,471	2,228	2,161	1,760
75	1,800	1,935	2,305	2,065	2,293	2,073	2,011	1,639	1,998	2,149	2,558	2,293	2,546	2,302	2,232	1,818
76	1,854	1,994	2,374	2,134	2,362	2,142	2,078	1,693	2,057	2,214	2,635	2,369	2,622	2,378	2,307	1,879
77	1,909	2,054	2,445	2,205	2,433	2,214	2,147	1,748	2,119	2,279	2,714	2,447	2,700	2,456	2,383	1,941
78	1,967	2,116	2,519	2,277	2,506	2,286	2,217	1,807	2,183	2,348	2,796	2,528	2,782	2,538	2,462	2,004
79	2,025	2,179	2,593	2,352	2,581	2,361	2,291	1,865	2,248	2,418	2,880	2,611	2,865	2,621	2,543	2,071
80	2,086	2,245	2,671	2,429	2,659	2,439	2,366	1,926	2,315	2,491	2,966	2,697	2,951	2,707	2,625	2,139
81	2,138	2,300	2,738	2,496	2,726	2,506	2,430	1,979	2,374	2,553	3,039	2,770	3,025	2,781	2,698	2,197
82	2,180	2,346	2,793	2,550	2,780	2,560	2,483	2,023	2,421	2,605	3,100	2,830	3,085	2,842	2,757	2,245
83	2,224	2,393	2,849	2,605	2,835	2,615	2,537	2,067	2,469	2,657	3,163	2,892	3,148	2,904	2,816	2,293
84	2,269	2,441	2,906	2,662	2,892	2,673	2,592	2,111	2,519	2,709	3,226	2,954	3,210	2,966	2,877	2,344
85	2,303	2,478	2,950	2,705	2,935	2,715	2,635	2,145	2,556	2,751	3,274	3,003	3,258	3,014	2,923	2,382
86	2,338	2,515	2,993	2,749	2,980	2,760	2,677	2,180	2,594	2,792	3,324	3,051	3,307	3,064	2,972	2,420
87	2,361	2,540	3,023	2,778	3,010	2,790	2,706	2,203	2,621	2,820	3,357	3,084	3,340	3,096	3,004	2,446
88	2,385	2,566	3,054	2,808	3,039	2,820	2,735	2,228	2,647	2,847	3,390	3,118	3,373	3,129	3,036	2,473
89	2,408	2,591	3,084	2,839	3,069	2,850	2,765	2,252	2,674	2,876	3,424	3,151	3,407	3,164	3,068	2,499
90	2,432	2,617	3,115	2,869	3,100	2,881	2,795	2,276	2,700	2,905	3,458	3,186	3,441	3,197	3,102	2,525
91	2,456	2,644	3,146	2,900	3,131	2,912	2,824	2,300	2,727	2,934	3,493	3,219	3,475	3,232	3,135	2,553
92	2,482	2,670	3,177	2,931	3,163	2,943	2,854	2,325	2,754	2,964	3,527	3,255	3,511	3,267	3,168	2,581
93	2,506	2,697	3,210	2,964	3,195	2,975	2,885	2,349	2,782	2,993	3,563	3,289	3,545	3,302	3,203	2,608
94	2,531	2,723	3,242	2,995	3,226	3,006	2,916	2,375	2,809	3,023	3,598	3,325	3,581	3,337	3,237	2,636
95	2,556	2,751	3,274	3,027	3,258	3,038	2,947	2,400	2,838	3,053	3,634	3,360	3,617	3,373	3,272	2,665
96	2,582	2,778	3,307	3,059	3,291	3,072	2,980	2,427	2,866	3,084	3,671	3,396	3,652	3,409	3,307	2,693
97	2,608	2,806	3,340	3,092	3,324	3,104	3,011	2,452	2,895	3,114	3,708	3,433	3,689	3,445	3,342	2,722
98	2,634	2,834	3,373	3,126	3,357	3,137	3,043	2,478	2,923	3,145	3,744	3,470	3,726	3,482	3,378	2,751
99	2,660	2,862	3,407	3,159	3,390	3,171	3,076	2,505	2,953	3,177	3,782	3,506	3,764	3,520	3,414	2,781

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

THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN TEXAS ZIP CODES
770-773, 775

Attained	Female								Male							
Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	4,022	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4,464	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	1,497	1,611	1,918	1,658	1,909	1,665	1,615	1,316	1,663	1,788	2,130	1,840	2,119	1,848	1,793	1,459
66	1,497	1,611	1,918	1,658	1,909	1,665	1,615	1,316	1,663	1,788	2,130	1,840	2,119	1,848	1,793	1,459
67	1,497	1,611	1,918	1,658	1,909	1,665	1,615	1,316	1,663	1,788	2,130	1,840	2,119	1,848	1,793	1,459
68	1,565	1,684	2,004	1,743	1,995	1,750	1,699	1,383	1,738	1,869	2,225	1,935	2,215	1,944	1,885	1,535
69	1,628	1,751	2,085	1,823	2,075	1,831	1,776	1,446	1,807	1,945	2,314	2,024	2,303	2,032	1,971	1,605
70	1,693	1,822	2,168	1,906	2,157	1,914	1,856	1,511	1,879	2,022	2,407	2,115	2,395	2,124	2,060	1,678
71	1,761	1,894	2,255	1,992	2,244	2,000	1,940	1,580	1,954	2,102	2,504	2,210	2,491	2,220	2,153	1,754
72	1,831	1,970	2,345	2,082	2,333	2,090	2,026	1,650	2,032	2,187	2,604	2,310	2,591	2,320	2,249	1,832
73	1,886	2,030	2,415	2,151	2,404	2,160	2,095	1,705	2,093	2,253	2,681	2,387	2,668	2,397	2,325	1,894
74	1,942	2,090	2,487	2,223	2,476	2,232	2,164	1,763	2,156	2,320	2,761	2,467	2,749	2,477	2,402	1,957
75	2,001	2,153	2,562	2,297	2,551	2,306	2,237	1,822	2,221	2,390	2,844	2,550	2,830	2,560	2,483	2,022
76	2,061	2,217	2,639	2,372	2,627	2,383	2,312	1,883	2,287	2,461	2,930	2,634	2,915	2,645	2,566	2,090
77	2,123	2,284	2,719	2,452	2,706	2,461	2,387	1,945	2,356	2,535	3,018	2,721	3,003	2,732	2,650	2,159
78	2,186	2,353	2,800	2,532	2,786	2,543	2,466	2,009	2,427	2,612	3,108	2,811	3,094	2,822	2,737	2,230
79	2,252	2,423	2,884	2,615	2,870	2,625	2,547	2,075	2,500	2,690	3,202	2,904	3,186	2,915	2,828	2,302
80	2,320	2,496	2,970	2,701	2,957	2,712	2,631	2,142	2,575	2,770	3,297	2,998	3,282	3,011	2,920	2,378
81	2,377	2,558	3,045	2,775	3,030	2,786	2,703	2,201	2,639	2,839	3,380	3,081	3,364	3,092	2,999	2,443
82	2,425	2,609	3,106	2,836	3,091	2,846	2,761	2,248	2,692	2,896	3,448	3,148	3,430	3,160	3,065	2,497
83	2,474	2,661	3,168	2,897	3,152	2,908	2,821	2,298	2,746	2,954	3,517	3,215	3,499	3,228	3,131	2,551
84	2,523	2,715	3,232	2,960	3,215	2,972	2,882	2,347	2,800	3,013	3,587	3,286	3,570	3,298	3,199	2,606
85	2,561	2,755	3,280	3,008	3,264	3,020	2,929	2,385	2,843	3,059	3,641	3,338	3,623	3,352	3,251	2,648
86	2,599	2,797	3,329	3,057	3,313	3,068	2,976	2,424	2,885	3,104	3,695	3,393	3,678	3,406	3,304	2,691
87	2,625	2,824	3,363	3,090	3,347	3,102	3,008	2,451	2,914	3,135	3,732	3,429	3,715	3,443	3,340	2,720
88	2,652	2,853	3,396	3,123	3,380	3,135	3,042	2,477	2,943	3,167	3,770	3,466	3,751	3,480	3,375	2,750
89	2,678	2,882	3,430	3,157	3,413	3,169	3,074	2,504	2,973	3,198	3,808	3,504	3,789	3,518	3,412	2,778
90	2,705	2,911	3,464	3,191	3,448	3,203	3,107	2,530	3,003	3,230	3,846	3,542	3,827	3,556	3,449	2,808
91	2,732	2,939	3,499	3,225	3,482	3,237	3,141	2,558	3,033	3,263	3,884	3,580	3,865	3,594	3,486	2,839
92	2,759	2,969	3,534	3,260	3,517	3,273	3,174	2,585	3,062	3,295	3,923	3,618	3,903	3,633	3,524	2,869
93	2,786	2,998	3,570	3,295	3,552	3,307	3,209	2,613	3,094	3,328	3,962	3,657	3,942	3,672	3,562	2,900
94	2,815	3,028	3,605	3,330	3,587	3,343	3,243	2,642	3,125	3,361	4,002	3,696	3,982	3,711	3,600	2,931
95	2,843	3,059	3,641	3,366	3,624	3,379	3,278	2,669	3,156	3,395	4,041	3,736	4,022	3,751	3,639	2,964
96	2,872	3,089	3,678	3,402	3,659	3,416	3,313	2,698	3,187	3,429	4,081	3,777	4,062	3,790	3,678	2,995
97	2,900	3,120	3,715	3,439	3,696	3,452	3,349	2,727	3,219	3,464	4,123	3,817	4,103	3,832	3,717	3,027
98	2,929	3,151	3,751	3,475	3,733	3,489	3,384	2,757	3,251	3,498	4,164	3,858	4,143	3,872	3,756	3,059
99	2,958	3,183	3,789	3,512	3,771	3,526	3,420	2,785	3,283	3,533	4,206	3,899	4,185	3,915	3,796	3,092

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

THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN TEXAS ZIP CODES
750-753, 760, 761, 774, 776, 777, 782, 784, 793, 794

Attained	Female								Male							
Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	3,302	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3,666	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	1,230	1,323	1,575	1,361	1,568	1,367	1,326	1,079	1,365	1,469	1,748	1,511	1,740	1,517	1,472	1,199
66	1,230	1,323	1,575	1,361	1,568	1,367	1,326	1,079	1,365	1,469	1,748	1,511	1,740	1,517	1,472	1,199
67	1,230	1,323	1,575	1,361	1,568	1,367	1,326	1,079	1,365	1,469	1,748	1,511	1,740	1,517	1,472	1,199
68	1,285	1,383	1,646	1,431	1,638	1,437	1,394	1,135	1,427	1,535	1,827	1,589	1,819	1,596	1,548	1,260
69	1,337	1,439	1,712	1,497	1,703	1,503	1,457	1,188	1,484	1,596	1,901	1,661	1,891	1,668	1,618	1,318
70	1,390	1,495	1,781	1,565	1,771	1,571	1,524	1,241	1,544	1,660	1,976	1,737	1,967	1,744	1,692	1,378
71	1,446	1,555	1,851	1,635	1,843	1,642	1,593	1,297	1,604	1,726	2,055	1,815	2,045	1,823	1,768	1,440
72	1,504	1,618	1,926	1,708	1,916	1,716	1,664	1,356	1,668	1,796	2,138	1,896	2,127	1,905	1,847	1,505
73	1,549	1,666	1,983	1,766	1,974	1,773	1,720	1,401	1,719	1,849	2,202	1,960	2,190	1,968	1,909	1,555
74	1,595	1,716	2,043	1,825	2,033	1,832	1,778	1,448	1,770	1,905	2,268	2,025	2,256	2,034	1,973	1,607
75	1,643	1,767	2,104	1,886	2,094	1,893	1,836	1,496	1,824	1,962	2,335	2,094	2,325	2,102	2,038	1,660
76	1,693	1,821	2,167	1,949	2,157	1,956	1,897	1,546	1,878	2,021	2,406	2,163	2,394	2,171	2,106	1,716
77	1,743	1,875	2,232	2,013	2,222	2,021	1,960	1,596	1,935	2,081	2,478	2,234	2,465	2,243	2,176	1,772
78	1,796	1,932	2,300	2,079	2,288	2,087	2,024	1,650	1,993	2,144	2,553	2,308	2,540	2,317	2,248	1,830
79	1,849	1,990	2,368	2,147	2,356	2,156	2,092	1,703	2,053	2,208	2,629	2,384	2,616	2,393	2,322	1,891
80	1,905	2,050	2,439	2,218	2,428	2,227	2,160	1,759	2,114	2,274	2,708	2,462	2,694	2,472	2,397	1,953
81	1,952	2,100	2,500	2,279	2,489	2,288	2,219	1,807	2,167	2,331	2,775	2,529	2,762	2,539	2,463	2,006
82	1,991	2,142	2,550	2,328	2,538	2,337	2,267	1,847	2,210	2,378	2,831	2,584	2,817	2,595	2,517	2,050
83	2,031	2,185	2,601	2,378	2,588	2,388	2,316	1,887	2,254	2,426	2,888	2,641	2,874	2,651	2,571	2,094
84	2,072	2,229	2,653	2,431	2,641	2,440	2,367	1,928	2,300	2,474	2,945	2,697	2,931	2,708	2,627	2,140
85	2,103	2,263	2,693	2,470	2,680	2,479	2,406	1,958	2,334	2,512	2,989	2,742	2,975	2,752	2,669	2,175
86	2,135	2,296	2,733	2,510	2,721	2,520	2,444	1,991	2,369	2,549	3,035	2,786	3,020	2,797	2,713	2,209
87	2,156	2,319	2,760	2,537	2,748	2,547	2,471	2,012	2,393	2,575	3,065	2,816	3,049	2,827	2,743	2,233
88	2,178	2,343	2,789	2,564	2,775	2,575	2,497	2,034	2,417	2,600	3,095	2,847	3,080	2,857	2,772	2,258
89	2,199	2,366	2,816	2,592	2,802	2,602	2,524	2,056	2,441	2,626	3,126	2,877	3,111	2,889	2,801	2,282
90	2,221	2,390	2,844	2,620	2,831	2,630	2,552	2,078	2,465	2,652	3,157	2,909	3,142	2,919	2,832	2,306
91	2,243	2,414	2,873	2,648	2,859	2,659	2,579	2,100	2,490	2,679	3,189	2,939	3,173	2,951	2,862	2,331
92	2,266	2,438	2,901	2,676	2,888	2,687	2,606	2,123	2,515	2,706	3,220	2,972	3,206	2,983	2,893	2,356
93	2,288	2,462	2,931	2,706	2,917	2,716	2,634	2,145	2,540	2,733	3,253	3,003	3,237	3,015	2,924	2,381
94	2,311	2,486	2,960	2,734	2,945	2,745	2,663	2,168	2,565	2,760	3,285	3,036	3,270	3,047	2,956	2,407
95	2,334	2,512	2,989	2,764	2,975	2,774	2,691	2,191	2,591	2,788	3,318	3,068	3,302	3,080	2,987	2,433
96	2,357	2,537	3,020	2,793	3,005	2,805	2,721	2,216	2,617	2,816	3,352	3,101	3,335	3,112	3,020	2,459
97	2,381	2,562	3,049	2,823	3,035	2,834	2,749	2,239	2,643	2,843	3,385	3,134	3,368	3,146	3,051	2,485
98	2,405	2,587	3,080	2,854	3,065	2,864	2,778	2,263	2,669	2,872	3,419	3,168	3,402	3,179	3,084	2,512
99	2,429	2,613	3,111	2,884	3,095	2,895	2,809	2,287	2,696	2,901	3,453	3,201	3,437	3,214	3,117	2,539

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

THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN TEXAS ZIP CODES
750-753, 760, 761, 774, 776, 777, 782, 784, 793, 794

Attained	Female								Male							
Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	3,672	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4,076	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	1,367	1,471	1,751	1,514	1,743	1,520	1,474	1,201	1,518	1,633	1,945	1,680	1,935	1,687	1,637	1,332
66	1,367	1,471	1,751	1,514	1,743	1,520	1,474	1,201	1,518	1,633	1,945	1,680	1,935	1,687	1,637	1,332
67	1,367	1,471	1,751	1,514	1,743	1,520	1,474	1,201	1,518	1,633	1,945	1,680	1,935	1,687	1,637	1,332
68	1,429	1,537	1,830	1,592	1,822	1,598	1,551	1,263	1,587	1,706	2,032	1,767	2,022	1,775	1,721	1,402
69	1,487	1,599	1,904	1,664	1,894	1,672	1,621	1,320	1,650	1,776	2,113	1,848	2,103	1,855	1,800	1,466
70	1,546	1,663	1,979	1,740	1,970	1,747	1,695	1,380	1,716	1,846	2,198	1,931	2,187	1,939	1,881	1,532
71	1,608	1,729	2,059	1,819	2,049	1,826	1,771	1,443	1,784	1,919	2,286	2,018	2,274	2,027	1,966	1,601
72	1,672	1,799	2,141	1,901	2,130	1,908	1,850	1,507	1,855	1,997	2,377	2,109	2,366	2,118	2,054	1,673
73	1,722	1,853	2,205	1,964	2,195	1,972	1,913	1,557	1,911	2,057	2,448	2,180	2,436	2,188	2,123	1,729
74	1,773	1,908	2,271	2,030	2,261	2,038	1,976	1,610	1,969	2,118	2,521	2,252	2,510	2,262	2,193	1,787
75	1,827	1,966	2,339	2,097	2,329	2,105	2,042	1,663	2,028	2,182	2,597	2,328	2,584	2,337	2,267	1,846
76	1,882	2,024	2,410	2,166	2,398	2,176	2,111	1,719	2,088	2,247	2,675	2,405	2,662	2,415	2,343	1,908
77	1,938	2,085	2,482	2,239	2,471	2,247	2,180	1,776	2,151	2,314	2,755	2,484	2,742	2,495	2,419	1,971
78	1,996	2,148	2,557	2,312	2,544	2,322	2,251	1,834	2,216	2,385	2,838	2,566	2,825	2,577	2,499	2,036
79	2,056	2,212	2,633	2,388	2,621	2,397	2,326	1,894	2,283	2,456	2,923	2,651	2,909	2,662	2,582	2,102
80	2,118	2,279	2,712	2,466	2,700	2,476	2,402	1,956	2,351	2,529	3,010	2,737	2,997	2,749	2,666	2,171
81	2,170	2,335	2,780	2,534	2,767	2,544	2,468	2,010	2,410	2,592	3,086	2,813	3,071	2,823	2,738	2,230
82	2,214	2,382	2,836	2,589	2,822	2,599	2,521	2,053	2,458	2,644	3,148	2,874	3,132	2,885	2,798	2,280
83	2,259	2,430	2,893	2,645	2,878	2,655	2,576	2,098	2,507	2,697	3,211	2,936	3,195	2,947	2,859	2,329
84	2,304	2,479	2,951	2,703	2,936	2,713	2,631	2,143	2,557	2,751	3,275	3,000	3,259	3,011	2,921	2,379
85	2,338	2,516	2,995	2,747	2,980	2,757	2,674	2,178	2,596	2,793	3,324	3,048	3,308	3,061	2,968	2,418
86	2,373	2,554	3,040	2,791	3,025	2,801	2,717	2,213	2,634	2,834	3,374	3,098	3,358	3,110	3,017	2,457
87	2,397	2,579	3,070	2,821	3,056	2,832	2,747	2,238	2,661	2,862	3,407	3,131	3,392	3,144	3,049	2,483
88	2,421	2,605	3,101	2,852	3,086	2,862	2,777	2,262	2,687	2,892	3,442	3,165	3,425	3,177	3,082	2,511
89	2,445	2,631	3,132	2,882	3,116	2,894	2,807	2,286	2,714	2,920	3,477	3,199	3,460	3,212	3,115	2,537
90	2,470	2,658	3,163	2,914	3,148	2,924	2,837	2,310	2,742	2,949	3,511	3,234	3,494	3,247	3,149	2,564
91	2,495	2,684	3,195	2,944	3,179	2,956	2,868	2,335	2,769	2,979	3,546	3,269	3,529	3,281	3,183	2,592
92	2,519	2,711	3,227	2,977	3,211	2,988	2,898	2,360	2,796	3,008	3,582	3,303	3,564	3,317	3,217	2,620
93	2,544	2,737	3,259	3,008	3,243	3,020	2,930	2,386	2,825	3,039	3,617	3,339	3,599	3,353	3,252	2,648
94	2,570	2,765	3,292	3,041	3,275	3,052	2,961	2,412	2,853	3,069	3,654	3,375	3,636	3,388	3,287	2,676
95	2,596	2,793	3,324	3,073	3,309	3,085	2,993	2,437	2,881	3,100	3,690	3,411	3,672	3,425	3,322	2,706
96	2,622	2,820	3,358	3,106	3,341	3,119	3,025	2,463	2,910	3,131	3,726	3,448	3,709	3,461	3,358	2,734
97	2,648	2,849	3,392	3,140	3,375	3,152	3,058	2,490	2,939	3,163	3,764	3,485	3,746	3,499	3,394	2,764
98	2,674	2,877	3,425	3,173	3,408	3,186	3,090	2,517	2,968	3,194	3,802	3,523	3,783	3,535	3,429	2,793
99	2,701	2,906	3,460	3,207	3,443	3,219	3,123	2,543	2,998	3,226	3,840	3,560	3,821	3,574	3,466	2,823

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

THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN TEXAS ZIP CODES ALL EXCEPT
750-753, 760, 761, 770-777, 782, 784, 793, 794

Attained	Female								Male							
Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	3,051	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3,386	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	1,136	1,222	1,455	1,257	1,448	1,263	1,225	997	1,261	1,357	1,615	1,396	1,607	1,402	1,360	1,108
66	1,136	1,222	1,455	1,257	1,448	1,263	1,225	997	1,261	1,357	1,615	1,396	1,607	1,402	1,360	1,108
67	1,136	1,222	1,455	1,257	1,448	1,263	1,225	997	1,261	1,357	1,615	1,396	1,607	1,402	1,360	1,108
68	1,187	1,277	1,521	1,322	1,513	1,328	1,288	1,049	1,318	1,418	1,688	1,468	1,680	1,474	1,430	1,164
69	1,235	1,329	1,581	1,383	1,573	1,388	1,346	1,097	1,371	1,474	1,756	1,535	1,747	1,541	1,495	1,217
70	1,284	1,381	1,645	1,445	1,636	1,451	1,407	1,147	1,426	1,534	1,826	1,604	1,817	1,611	1,563	1,273
71	1,336	1,437	1,710	1,510	1,702	1,517	1,471	1,198	1,482	1,595	1,898	1,677	1,890	1,684	1,633	1,330
72	1,389	1,495	1,779	1,578	1,770	1,585	1,537	1,252	1,541	1,659	1,975	1,752	1,965	1,760	1,706	1,390
73	1,431	1,539	1,832	1,632	1,824	1,638	1,589	1,294	1,588	1,708	2,034	1,811	2,023	1,818	1,763	1,437
74	1,473	1,585	1,888	1,686	1,878	1,693	1,642	1,338	1,635	1,760	2,095	1,871	2,085	1,879	1,823	1,484
75	1,518	1,633	1,944	1,742	1,934	1,749	1,697	1,382	1,685	1,813	2,157	1,934	2,148	1,942	1,883	1,534
76	1,564	1,682	2,002	1,800	1,992	1,807	1,753	1,428	1,735	1,867	2,222	1,998	2,212	2,006	1,946	1,585
77	1,610	1,732	2,062	1,859	2,053	1,867	1,811	1,474	1,788	1,923	2,289	2,064	2,278	2,072	2,010	1,637
78	1,659	1,785	2,124	1,921	2,114	1,928	1,870	1,524	1,841	1,981	2,358	2,132	2,346	2,141	2,077	1,691
79	1,708	1,838	2,187	1,984	2,177	1,991	1,932	1,573	1,896	2,040	2,429	2,202	2,416	2,211	2,145	1,747
80	1,760	1,893	2,253	2,049	2,243	2,057	1,995	1,625	1,953	2,101	2,502	2,275	2,489	2,283	2,215	1,804
81	1,803	1,940	2,310	2,105	2,299	2,114	2,050	1,669	2,002	2,153	2,564	2,337	2,551	2,345	2,276	1,853
82	1,839	1,979	2,356	2,150	2,344	2,159	2,094	1,706	2,042	2,197	2,615	2,387	2,603	2,397	2,325	1,893
83	1,876	2,019	2,403	2,197	2,391	2,206	2,140	1,743	2,083	2,241	2,668	2,440	2,655	2,449	2,376	1,934
84	1,914	2,059	2,451	2,246	2,440	2,254	2,186	1,781	2,124	2,285	2,721	2,492	2,707	2,502	2,427	1,977
85	1,943	2,090	2,488	2,281	2,475	2,290	2,222	1,809	2,156	2,320	2,762	2,533	2,748	2,542	2,466	2,009
86	1,972	2,121	2,525	2,318	2,513	2,328	2,258	1,839	2,188	2,355	2,803	2,573	2,790	2,584	2,506	2,041
87	1,991	2,143	2,550	2,344	2,538	2,353	2,282	1,859	2,211	2,378	2,831	2,602	2,817	2,611	2,534	2,063
88	2,012	2,164	2,576	2,369	2,564	2,378	2,307	1,879	2,233	2,402	2,860	2,630	2,845	2,639	2,561	2,086
89	2,031	2,185	2,602	2,395	2,589	2,404	2,332	1,899	2,255	2,426	2,888	2,658	2,874	2,668	2,588	2,108
90	2,052	2,208	2,628	2,420	2,615	2,430	2,357	1,920	2,278	2,450	2,917	2,687	2,902	2,697	2,616	2,130
91	2,072	2,230	2,654	2,446	2,641	2,456	2,382	1,940	2,300	2,474	2,946	2,715	2,931	2,726	2,644	2,153
92	2,093	2,252	2,680	2,473	2,668	2,482	2,408	1,961	2,323	2,500	2,975	2,745	2,961	2,756	2,672	2,177
93	2,114	2,275	2,707	2,500	2,695	2,509	2,434	1,982	2,346	2,525	3,005	2,774	2,991	2,785	2,701	2,200
94	2,135	2,297	2,734	2,526	2,721	2,536	2,460	2,003	2,370	2,550	3,035	2,804	3,021	2,815	2,731	2,223
95	2,156	2,320	2,762	2,553	2,748	2,563	2,486	2,024	2,394	2,575	3,065	2,834	3,051	2,845	2,760	2,247
96	2,178	2,344	2,790	2,580	2,776	2,591	2,513	2,047	2,417	2,602	3,096	2,864	3,081	2,875	2,790	2,272
97	2,200	2,367	2,817	2,608	2,803	2,618	2,539	2,068	2,441	2,627	3,127	2,895	3,112	2,906	2,819	2,296
98	2,221	2,390	2,845	2,636	2,831	2,646	2,567	2,090	2,466	2,653	3,158	2,926	3,143	2,937	2,849	2,320
99	2,244	2,414	2,874	2,665	2,860	2,674	2,595	2,113	2,491	2,680	3,190	2,958	3,175	2,969	2,880	2,345

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

THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN TEXAS ZIP CODES ALL EXCEPT
750-753, 760, 761, 770-777, 782, 784, 793, 794

Attained Age	Female								Male							
	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	3,392	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3,766	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	1,263	1,359	1,618	1,399	1,610	1,405	1,362	1,110	1,403	1,508	1,796	1,552	1,788	1,559	1,512	1,231
66	1,263	1,359	1,618	1,399	1,610	1,405	1,362	1,110	1,403	1,508	1,796	1,552	1,788	1,559	1,512	1,231
67	1,263	1,359	1,618	1,399	1,610	1,405	1,362	1,110	1,403	1,508	1,796	1,552	1,788	1,559	1,512	1,231
68	1,320	1,420	1,691	1,471	1,683	1,476	1,433	1,167	1,466	1,576	1,877	1,633	1,868	1,639	1,590	1,295
69	1,374	1,477	1,759	1,537	1,750	1,544	1,498	1,219	1,524	1,640	1,952	1,707	1,943	1,714	1,663	1,354
70	1,428	1,536	1,828	1,607	1,820	1,614	1,566	1,275	1,585	1,705	2,030	1,784	2,021	1,792	1,737	1,415
71	1,485	1,598	1,902	1,680	1,892	1,687	1,636	1,333	1,648	1,773	2,112	1,864	2,101	1,872	1,816	1,479
72	1,544	1,662	1,978	1,756	1,968	1,762	1,709	1,392	1,714	1,845	2,196	1,949	2,185	1,956	1,897	1,545
73	1,591	1,712	2,037	1,814	2,027	1,822	1,767	1,439	1,765	1,900	2,261	2,014	2,250	2,021	1,961	1,598
74	1,638	1,762	2,098	1,875	2,088	1,883	1,826	1,487	1,819	1,956	2,329	2,081	2,318	2,089	2,026	1,651
75	1,688	1,816	2,161	1,937	2,151	1,945	1,887	1,536	1,873	2,016	2,399	2,150	2,387	2,159	2,094	1,705
76	1,738	1,870	2,226	2,001	2,215	2,010	1,950	1,588	1,929	2,076	2,472	2,221	2,459	2,231	2,164	1,762
77	1,791	1,926	2,293	2,068	2,282	2,076	2,014	1,640	1,988	2,138	2,545	2,295	2,533	2,305	2,235	1,821
78	1,844	1,985	2,362	2,136	2,350	2,145	2,080	1,695	2,047	2,203	2,622	2,371	2,609	2,380	2,309	1,881
79	1,899	2,044	2,433	2,206	2,421	2,215	2,149	1,750	2,109	2,269	2,700	2,449	2,687	2,459	2,385	1,942
80	1,956	2,105	2,506	2,279	2,494	2,287	2,219	1,807	2,172	2,337	2,781	2,529	2,768	2,539	2,463	2,006
81	2,005	2,157	2,569	2,341	2,556	2,350	2,280	1,857	2,226	2,395	2,851	2,599	2,837	2,608	2,530	2,060
82	2,046	2,201	2,620	2,392	2,607	2,401	2,329	1,896	2,271	2,442	2,908	2,655	2,894	2,666	2,585	2,106
83	2,086	2,245	2,672	2,443	2,659	2,453	2,379	1,938	2,316	2,492	2,966	2,712	2,952	2,723	2,641	2,151
84	2,128	2,290	2,726	2,497	2,712	2,506	2,431	1,980	2,362	2,541	3,025	2,771	3,011	2,782	2,699	2,198
85	2,160	2,324	2,766	2,538	2,753	2,547	2,471	2,012	2,398	2,580	3,071	2,816	3,056	2,828	2,742	2,234
86	2,192	2,359	2,808	2,578	2,795	2,588	2,510	2,045	2,434	2,618	3,117	2,862	3,102	2,873	2,787	2,270
87	2,215	2,382	2,836	2,606	2,823	2,616	2,538	2,067	2,458	2,644	3,148	2,893	3,133	2,904	2,817	2,294
88	2,237	2,407	2,864	2,635	2,851	2,644	2,566	2,089	2,482	2,671	3,180	2,924	3,164	2,935	2,847	2,319
89	2,259	2,431	2,894	2,663	2,879	2,673	2,593	2,112	2,507	2,698	3,212	2,956	3,196	2,967	2,878	2,344
90	2,281	2,455	2,922	2,692	2,908	2,701	2,621	2,134	2,533	2,725	3,244	2,988	3,228	2,999	2,909	2,369
91	2,305	2,479	2,952	2,720	2,937	2,731	2,649	2,157	2,558	2,752	3,276	3,020	3,260	3,031	2,940	2,395
92	2,327	2,505	2,981	2,750	2,966	2,761	2,677	2,181	2,583	2,779	3,309	3,052	3,292	3,064	2,972	2,420
93	2,350	2,529	3,011	2,779	2,996	2,790	2,706	2,204	2,609	2,807	3,342	3,085	3,325	3,097	3,004	2,446
94	2,375	2,554	3,041	2,809	3,025	2,820	2,735	2,228	2,635	2,835	3,376	3,118	3,359	3,130	3,036	2,473
95	2,398	2,580	3,071	2,839	3,056	2,850	2,765	2,251	2,662	2,863	3,409	3,152	3,392	3,164	3,069	2,500
96	2,422	2,605	3,102	2,869	3,087	2,881	2,795	2,276	2,688	2,893	3,443	3,185	3,426	3,197	3,102	2,526
97	2,446	2,632	3,133	2,900	3,118	2,912	2,825	2,300	2,715	2,922	3,477	3,219	3,461	3,232	3,135	2,553
98	2,471	2,658	3,164	2,931	3,149	2,943	2,855	2,325	2,742	2,951	3,512	3,254	3,495	3,266	3,168	2,580
99	2,495	2,685	3,196	2,962	3,181	2,974	2,885	2,349	2,769	2,980	3,547	3,288	3,530	3,302	3,202	2,608

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

The Manhattan Life Insurance 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.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.

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 The Manhattan Life Insurance 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 The Manhattan Life Insurance 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 serviced 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 $1184	$0	$1184 (Part A deductible)
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $592 a day	$592 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 $148 a day	$0	Up to $148 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			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 $147 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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

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 $1184	$1184 (Part A deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $592 a day	$592 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 $148 a day	$0	Up to $148 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			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 B

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

*Once you have been billed $147 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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

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 $1184	$1184 (Part A deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $592 a day	$592 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 $148 a day	Up to $148 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			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 C

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

*Once you have been billed $147 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 $147 of Medicare Approved Amounts*	$0	$147 (Part B deductible)	$0
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 $147 of Medicare Approved Amounts*	$0	$147 (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

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $147 of Medicare Approved Amounts*	$0	$147 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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 D

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 $1184	$1184 (Part A deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $592 a day	$592 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 $148 a day	Up to $148 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 D

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

*Once you have been billed $147 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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 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 $1184	$1184 (Part A deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $592 a day	$592 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 $148 a day	Up to $148 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			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 $147 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 $147 of Medicare Approved Amounts*	$0	$147 (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 $147 of Medicare Approved amounts*	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$147 (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 $1184	$1184 (Part A deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $592 a day	$592 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 $148 a day	Up to $148 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			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 $147 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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 M

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 $1184	$592 (50% Part A deductible)	$592 (50% Part A deductible)
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $592 a day	$592 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 $148 a day	Up to $148 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 M

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

*Once you have been billed $147 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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $1184	$1184 (Part A deductible)	$0
61st thru 90th day	All but $296 a day	$296 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $592 a day	$592 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 $148 a day	Up to $148 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			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited 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 $147 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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts*	$0	$0	$147 (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 $147 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $147 (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.