

Manhattan Life Application Packet

Thank you for your interest in the Manhattan Life Medicare Supplement plan!

Attached is a copy of the policy Outline of Coverage and we have supplied you with a link to a printable copy of the Enrollment.

Should you decide to apply by upload/mail/fax/email, the printable application needs to be reviewed and signed by an Agent before it can be submitted to Manhattan Life. You may upload, email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: cs@cda-insurance.com
- Secure File Upload: [Click here](#)
- Mail: CDA Insurance LLC
PO Box 26540
Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf)
Download Policy Outline (.pdf)
Download Application (.pdf)

Our website: <http://www.medicare-texas.net>

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

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 \$2200 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2200. 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 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	7,018	N/A	N/A	N/A	N/A	N/A	N/A	N/A	7,792	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	1,917	1,749	2,083	1,800	2,072	1,525	1,655	1,219	2,129	1,941	2,312	1,999	2,299	1,694	1,837	1,354
66	1,917	1,749	2,083	1,800	2,072	1,525	1,655	1,219	2,129	1,941	2,312	1,999	2,299	1,694	1,837	1,354
67	1,917	1,749	2,083	1,800	2,072	1,525	1,655	1,219	2,129	1,941	2,312	1,999	2,299	1,694	1,837	1,354
68	2,003	1,829	2,177	1,893	2,164	1,581	1,739	1,265	2,225	2,029	2,416	2,100	2,404	1,758	1,931	1,406
69	2,085	1,903	2,263	1,979	2,252	1,635	1,818	1,309	2,313	2,110	2,513	2,197	2,500	1,818	2,018	1,454
70	2,167	1,977	2,355	2,069	2,341	1,694	1,900	1,354	2,405	2,195	2,612	2,295	2,600	1,879	2,109	1,503
71	2,253	2,055	2,448	2,161	2,437	1,758	1,987	1,406	2,500	2,283	2,716	2,400	2,705	1,950	2,205	1,561
72	2,344	2,139	2,545	2,259	2,533	1,824	2,076	1,459	2,601	2,374	2,826	2,507	2,812	2,024	2,303	1,618
73	2,415	2,202	2,623	2,335	2,609	1,875	2,146	1,501	2,680	2,444	2,912	2,593	2,895	2,083	2,382	1,666
74	2,486	2,268	2,701	2,413	2,688	1,930	2,217	1,542	2,759	2,519	2,998	2,677	2,983	2,139	2,461	1,711
75	2,562	2,336	2,782	2,493	2,768	1,984	2,291	1,586	2,844	2,596	3,088	2,768	3,074	2,201	2,543	1,762
76	2,638	2,407	2,866	2,576	2,851	2,037	2,367	1,630	2,929	2,673	3,181	2,860	3,165	2,259	2,627	1,807
77	2,717	2,478	2,952	2,662	2,938	2,091	2,445	1,672	3,018	2,752	3,275	2,954	3,260	2,318	2,714	1,855
78	2,799	2,555	3,041	2,749	3,025	2,144	2,524	1,715	3,106	2,835	3,375	3,051	3,358	2,382	2,805	1,904
79	2,883	2,630	3,130	2,839	3,115	2,200	2,609	1,761	3,199	2,919	3,475	3,152	3,458	2,443	2,895	1,954
80	2,968	2,709	3,225	2,931	3,209	2,261	2,693	1,808	3,294	3,007	3,580	3,256	3,563	2,508	2,990	2,006
81	3,043	2,776	3,305	3,012	3,290	2,321	2,768	1,857	3,378	3,083	3,670	3,343	3,650	2,576	3,073	2,062
82	3,103	2,832	3,372	3,077	3,356	2,370	2,827	1,896	3,445	3,144	3,742	3,417	3,724	2,630	3,140	2,105
83	3,166	2,889	3,439	3,144	3,422	2,421	2,889	1,935	3,514	3,206	3,818	3,491	3,800	2,689	3,207	2,151
84	3,229	2,946	3,509	3,213	3,491	2,475	2,952	1,978	3,585	3,271	3,894	3,566	3,874	2,746	3,276	2,198
85	3,278	2,991	3,562	3,265	3,542	2,514	3,000	2,010	3,639	3,321	3,953	3,624	3,933	2,789	3,329	2,231
86	3,327	3,035	3,613	3,318	3,597	2,562	3,049	2,052	3,693	3,371	4,012	3,683	3,992	2,845	3,383	2,277
87	3,360	3,066	3,649	3,355	3,633	2,614	3,081	2,092	3,731	3,404	4,053	3,723	4,031	2,903	3,420	2,322
88	3,395	3,097	3,687	3,390	3,670	2,666	3,114	2,133	3,769	3,437	4,093	3,763	4,071	2,960	3,458	2,369
89	3,427	3,128	3,723	3,428	3,706	2,719	3,149	2,175	3,805	3,472	4,133	3,804	4,114	3,019	3,495	2,415
90	3,462	3,159	3,761	3,464	3,742	2,774	3,182	2,218	3,843	3,508	4,175	3,846	4,154	3,080	3,532	2,464
91	3,496	3,191	3,798	3,501	3,780	2,828	3,217	2,263	3,881	3,541	4,215	3,886	4,196	3,142	3,570	2,514
92	3,533	3,223	3,835	3,539	3,818	2,885	3,250	2,307	3,920	3,578	4,257	3,928	4,239	3,204	3,608	2,562
93	3,566	3,256	3,874	3,578	3,856	2,943	3,286	2,355	3,959	3,613	4,300	3,969	4,279	3,269	3,647	2,615
94	3,603	3,288	3,913	3,614	3,894	3,004	3,321	2,401	3,999	3,649	4,344	4,014	4,323	3,333	3,687	2,666
95	3,639	3,321	3,953	3,654	3,933	3,062	3,357	2,450	4,039	3,686	4,386	4,056	4,365	3,402	3,726	2,721
96	3,675	3,355	3,992	3,693	3,973	3,125	3,394	2,500	4,078	3,723	4,431	4,099	4,409	3,468	3,766	2,774
97	3,711	3,388	4,031	3,734	4,012	3,186	3,429	2,548	4,119	3,759	4,476	4,143	4,453	3,537	3,805	2,829
98	3,748	3,421	4,071	3,774	4,053	3,249	3,465	2,599	4,161	3,796	4,520	4,188	4,498	3,609	3,846	2,888
99	3,786	3,456	4,114	3,813	4,093	3,314	3,503	2,652	4,203	3,835	4,566	4,232	4,544	3,680	3,888	2,944

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

Semi Annual 1/2	Quarterly 1/4	Monthly 1/12
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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 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	7,806	N/A	N/A	N/A	N/A	N/A	N/A	N/A	8,663	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	2,132	1,945	2,316	2,002	2,305	1,697	1,839	1,357	2,367	2,159	2,571	2,222	2,559	1,881	2,041	1,507
66	2,132	1,945	2,316	2,002	2,305	1,697	1,839	1,357	2,367	2,159	2,571	2,222	2,559	1,881	2,041	1,507
67	2,132	1,945	2,316	2,002	2,305	1,697	1,839	1,357	2,367	2,159	2,571	2,222	2,559	1,881	2,041	1,507
68	2,228	2,032	2,421	2,106	2,408	1,761	1,934	1,408	2,474	2,255	2,686	2,336	2,674	1,956	2,147	1,564
69	2,318	2,115	2,517	2,200	2,505	1,820	2,023	1,456	2,571	2,348	2,793	2,443	2,781	2,019	2,245	1,616
70	2,410	2,199	2,616	2,299	2,604	1,884	2,115	1,507	2,674	2,440	2,906	2,554	2,891	2,090	2,346	1,671
71	2,506	2,287	2,721	2,404	2,708	1,956	2,209	1,564	2,781	2,537	3,022	2,668	3,007	2,169	2,452	1,735
72	2,606	2,378	2,831	2,513	2,818	2,027	2,307	1,622	2,892	2,640	3,143	2,788	3,128	2,252	2,561	1,801
73	2,683	2,451	2,915	2,597	2,901	2,088	2,386	1,670	2,980	2,719	3,235	2,882	3,221	2,315	2,648	1,853
74	2,765	2,522	3,004	2,683	2,988	2,147	2,464	1,716	3,069	2,800	3,333	2,979	3,318	2,378	2,736	1,903
75	2,847	2,599	3,092	2,773	3,079	2,206	2,547	1,765	3,161	2,885	3,433	3,077	3,417	2,448	2,827	1,958
76	2,934	2,676	3,186	2,865	3,171	2,266	2,632	1,812	3,256	2,972	3,537	3,180	3,518	2,513	2,921	2,009
77	3,022	2,757	3,283	2,959	3,266	2,324	2,719	1,860	3,353	3,060	3,643	3,286	3,624	2,577	3,018	2,062
78	3,112	2,841	3,380	3,057	3,364	2,386	2,808	1,909	3,453	3,153	3,752	3,394	3,735	2,647	3,117	2,118
79	3,205	2,924	3,481	3,157	3,465	2,450	2,901	1,960	3,558	3,248	3,865	3,505	3,846	2,715	3,220	2,171
80	3,302	3,012	3,585	3,261	3,568	2,516	2,997	2,013	3,664	3,343	3,980	3,619	3,962	2,788	3,326	2,230
81	3,382	3,088	3,675	3,351	3,657	2,583	3,077	2,067	3,756	3,428	4,080	3,719	4,061	2,864	3,416	2,292
82	3,452	3,151	3,750	3,424	3,733	2,638	3,144	2,109	3,832	3,496	4,162	3,800	4,140	2,926	3,490	2,340
83	3,520	3,212	3,825	3,497	3,805	2,693	3,212	2,156	3,909	3,566	4,245	3,881	4,225	2,987	3,566	2,390
84	3,591	3,276	3,900	3,574	3,881	2,752	3,282	2,201	3,985	3,637	4,331	3,965	4,309	3,052	3,643	2,443
85	3,644	3,327	3,959	3,632	3,940	2,795	3,336	2,236	4,047	3,693	4,396	4,030	4,373	3,102	3,702	2,481
86	3,698	3,376	4,019	3,689	4,000	2,851	3,390	2,282	4,107	3,747	4,462	4,095	4,440	3,164	3,763	2,530
87	3,736	3,409	4,058	3,729	4,040	2,908	3,426	2,328	4,148	3,784	4,506	4,139	4,484	3,227	3,803	2,582
88	3,774	3,444	4,099	3,772	4,080	2,967	3,464	2,372	4,188	3,823	4,551	4,185	4,529	3,289	3,843	2,632
89	3,812	3,478	4,140	3,810	4,120	3,025	3,501	2,421	4,230	3,861	4,597	4,230	4,575	3,357	3,886	2,685
90	3,849	3,513	4,180	3,853	4,162	3,087	3,539	2,469	4,273	3,899	4,643	4,276	4,621	3,424	3,927	2,739
91	3,888	3,548	4,225	3,893	4,203	3,146	3,577	2,517	4,315	3,938	4,689	4,322	4,666	3,491	3,969	2,793
92	3,926	3,583	4,267	3,935	4,245	3,211	3,614	2,569	4,359	3,978	4,735	4,367	4,712	3,563	4,014	2,850
93	3,966	3,619	4,309	3,978	4,290	3,275	3,655	2,621	4,402	4,018	4,783	4,414	4,759	3,633	4,056	2,906
94	4,008	3,655	4,352	4,020	4,331	3,341	3,694	2,674	4,447	4,057	4,830	4,463	4,808	3,706	4,099	2,966
95	4,047	3,693	4,396	4,064	4,375	3,407	3,733	2,727	4,491	4,097	4,878	4,510	4,854	3,780	4,145	3,025
96	4,086	3,728	4,440	4,107	4,417	3,475	3,773	2,781	4,536	4,139	4,927	4,559	4,902	3,856	4,188	3,084
97	4,127	3,766	4,484	4,152	4,463	3,544	3,813	2,837	4,580	4,180	4,976	4,608	4,954	3,933	4,232	3,145
98	4,169	3,804	4,529	4,196	4,507	3,616	3,855	2,892	4,628	4,224	5,027	4,656	5,001	4,012	4,278	3,209
99	4,210	3,843	4,575	4,240	4,552	3,688	3,895	2,951	4,672	4,265	5,076	4,707	5,052	4,092	4,323	3,273

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

Semi Annual
1/2

Quarterly
1/4

Monthly
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 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	6,408	N/A	N/A	N/A	N/A	N/A	N/A	N/A	7,115	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	1,750	1,597	1,902	1,643	1,892	1,392	1,511	1,113	1,944	1,772	2,111	1,825	2,099	1,547	1,677	1,236
66	1,750	1,597	1,902	1,643	1,892	1,392	1,511	1,113	1,944	1,772	2,111	1,825	2,099	1,547	1,677	1,236
67	1,750	1,597	1,902	1,643	1,892	1,392	1,511	1,113	1,944	1,772	2,111	1,825	2,099	1,547	1,677	1,236
68	1,829	1,670	1,988	1,728	1,976	1,444	1,588	1,155	2,032	1,852	2,206	1,917	2,195	1,605	1,763	1,284
69	1,904	1,738	2,066	1,807	2,056	1,493	1,660	1,195	2,112	1,927	2,294	2,006	2,283	1,660	1,843	1,327
70	1,978	1,805	2,150	1,889	2,138	1,547	1,735	1,236	2,196	2,004	2,385	2,096	2,374	1,716	1,926	1,372
71	2,057	1,876	2,235	1,973	2,225	1,605	1,814	1,284	2,283	2,084	2,480	2,191	2,470	1,781	2,013	1,425
72	2,140	1,953	2,324	2,062	2,313	1,665	1,895	1,332	2,375	2,167	2,580	2,289	2,567	1,848	2,103	1,477
73	2,205	2,011	2,395	2,132	2,382	1,712	1,959	1,370	2,447	2,231	2,659	2,368	2,643	1,902	2,175	1,521
74	2,270	2,071	2,466	2,203	2,454	1,762	2,024	1,408	2,519	2,300	2,737	2,444	2,724	1,953	2,247	1,562
75	2,339	2,133	2,540	2,276	2,527	1,811	2,092	1,448	2,597	2,370	2,819	2,527	2,807	2,010	2,322	1,609
76	2,409	2,198	2,617	2,352	2,603	1,860	2,161	1,488	2,674	2,440	2,904	2,611	2,890	2,062	2,398	1,650
77	2,481	2,263	2,695	2,431	2,683	1,909	2,232	1,527	2,755	2,513	2,990	2,697	2,977	2,117	2,478	1,694
78	2,556	2,333	2,776	2,510	2,762	1,957	2,305	1,566	2,836	2,588	3,082	2,786	3,066	2,175	2,561	1,739
79	2,632	2,401	2,858	2,592	2,844	2,009	2,382	1,608	2,921	2,665	3,173	2,878	3,157	2,230	2,643	1,784
80	2,710	2,474	2,944	2,676	2,930	2,064	2,459	1,651	3,007	2,746	3,269	2,973	3,253	2,290	2,730	1,831
81	2,778	2,535	3,018	2,750	3,004	2,119	2,527	1,696	3,084	2,815	3,351	3,052	3,333	2,352	2,806	1,883
82	2,833	2,586	3,079	2,810	3,064	2,164	2,581	1,731	3,146	2,871	3,417	3,120	3,400	2,401	2,867	1,922
83	2,891	2,638	3,140	2,871	3,125	2,210	2,638	1,767	3,209	2,927	3,486	3,188	3,469	2,455	2,928	1,964
84	2,948	2,690	3,204	2,934	3,188	2,260	2,695	1,806	3,273	2,986	3,555	3,256	3,537	2,507	2,991	2,007
85	2,993	2,731	3,252	2,981	3,234	2,295	2,739	1,835	3,322	3,032	3,609	3,309	3,591	2,546	3,040	2,037
86	3,038	2,771	3,299	3,029	3,284	2,339	2,784	1,873	3,372	3,078	3,663	3,363	3,645	2,598	3,089	2,079
87	3,068	2,799	3,332	3,063	3,317	2,387	2,813	1,910	3,406	3,108	3,700	3,399	3,680	2,650	3,123	2,120
88	3,100	2,828	3,366	3,095	3,351	2,434	2,843	1,948	3,441	3,138	3,737	3,436	3,717	2,703	3,157	2,163
89	3,129	2,856	3,399	3,130	3,384	2,482	2,875	1,986	3,474	3,170	3,774	3,473	3,756	2,756	3,191	2,205
90	3,161	2,884	3,434	3,163	3,417	2,533	2,905	2,025	3,509	3,203	3,812	3,511	3,793	2,812	3,225	2,250
91	3,192	2,914	3,468	3,196	3,451	2,582	2,937	2,066	3,544	3,233	3,848	3,548	3,831	2,869	3,259	2,295
92	3,226	2,943	3,502	3,231	3,486	2,634	2,967	2,106	3,579	3,267	3,887	3,587	3,870	2,925	3,294	2,339
93	3,256	2,973	3,537	3,267	3,521	2,687	3,000	2,150	3,615	3,299	3,926	3,624	3,907	2,985	3,330	2,388
94	3,290	3,002	3,573	3,300	3,555	2,743	3,032	2,192	3,651	3,332	3,966	3,665	3,947	3,043	3,366	2,434
95	3,322	3,032	3,609	3,336	3,591	2,796	3,065	2,237	3,688	3,365	4,005	3,703	3,986	3,106	3,402	2,484
96	3,356	3,063	3,645	3,372	3,628	2,853	3,099	2,283	3,723	3,399	4,046	3,742	4,026	3,167	3,439	2,533
97	3,388	3,093	3,680	3,409	3,663	2,909	3,131	2,327	3,761	3,432	4,087	3,783	4,066	3,230	3,474	2,583
98	3,422	3,124	3,717	3,446	3,700	2,966	3,164	2,373	3,799	3,466	4,127	3,824	4,107	3,295	3,511	2,637
99	3,457	3,155	3,756	3,482	3,737	3,026	3,198	2,421	3,838	3,502	4,169	3,864	4,149	3,360	3,550	2,688

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

Semi Annual
1/2

Quarterly
1/4

Monthly
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 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	7,127	N/A	N/A	N/A	N/A	N/A	N/A	N/A	7,910	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	1,947	1,776	2,115	1,828	2,104	1,550	1,679	1,239	2,161	1,971	2,348	2,029	2,336	1,718	1,864	1,376
66	1,947	1,776	2,115	1,828	2,104	1,550	1,679	1,239	2,161	1,971	2,348	2,029	2,336	1,718	1,864	1,376
67	1,947	1,776	2,115	1,828	2,104	1,550	1,679	1,239	2,161	1,971	2,348	2,029	2,336	1,718	1,864	1,376
68	2,034	1,855	2,210	1,923	2,199	1,608	1,766	1,285	2,259	2,059	2,453	2,133	2,441	1,786	1,960	1,428
69	2,117	1,931	2,298	2,009	2,287	1,662	1,847	1,329	2,348	2,144	2,550	2,230	2,539	1,844	2,050	1,475
70	2,201	2,008	2,389	2,099	2,377	1,720	1,931	1,376	2,441	2,228	2,653	2,332	2,640	1,908	2,142	1,526
71	2,288	2,088	2,484	2,195	2,473	1,786	2,017	1,428	2,539	2,316	2,759	2,436	2,746	1,980	2,239	1,584
72	2,379	2,171	2,585	2,294	2,573	1,851	2,106	1,481	2,641	2,411	2,870	2,545	2,856	2,056	2,338	1,644
73	2,450	2,238	2,662	2,371	2,649	1,907	2,179	1,525	2,721	2,482	2,954	2,631	2,941	2,114	2,418	1,692
74	2,524	2,303	2,743	2,450	2,728	1,960	2,250	1,567	2,802	2,557	3,043	2,720	3,029	2,171	2,498	1,738
75	2,600	2,373	2,823	2,532	2,811	2,014	2,326	1,612	2,886	2,634	3,134	2,810	3,120	2,235	2,581	1,788
76	2,679	2,443	2,909	2,616	2,895	2,069	2,403	1,655	2,973	2,713	3,230	2,903	3,212	2,294	2,667	1,834
77	2,759	2,517	2,998	2,702	2,982	2,122	2,482	1,698	3,062	2,794	3,326	3,000	3,309	2,353	2,755	1,883
78	2,841	2,594	3,086	2,791	3,071	2,179	2,564	1,743	3,153	2,879	3,426	3,099	3,410	2,417	2,846	1,934
79	2,926	2,670	3,178	2,882	3,164	2,237	2,649	1,789	3,249	2,965	3,529	3,200	3,511	2,479	2,940	1,982
80	3,015	2,750	3,273	2,978	3,258	2,297	2,736	1,838	3,345	3,052	3,634	3,304	3,617	2,545	3,037	2,036
81	3,088	2,819	3,356	3,060	3,339	2,358	2,810	1,887	3,429	3,130	3,725	3,396	3,708	2,615	3,119	2,093
82	3,152	2,877	3,424	3,126	3,408	2,409	2,871	1,926	3,499	3,192	3,800	3,469	3,780	2,671	3,187	2,137
83	3,214	2,933	3,492	3,193	3,474	2,459	2,933	1,969	3,569	3,256	3,876	3,544	3,858	2,727	3,256	2,182
84	3,279	2,991	3,561	3,263	3,544	2,513	2,997	2,010	3,638	3,321	3,954	3,620	3,934	2,787	3,326	2,230
85	3,327	3,038	3,615	3,316	3,597	2,552	3,046	2,041	3,695	3,372	4,014	3,679	3,993	2,832	3,380	2,265
86	3,377	3,083	3,670	3,368	3,652	2,603	3,095	2,083	3,750	3,421	4,074	3,739	4,054	2,889	3,436	2,310
87	3,411	3,112	3,705	3,405	3,689	2,655	3,128	2,125	3,787	3,455	4,114	3,779	4,094	2,946	3,472	2,357
88	3,446	3,145	3,742	3,444	3,725	2,709	3,163	2,166	3,824	3,490	4,155	3,821	4,135	3,003	3,509	2,403
89	3,481	3,175	3,780	3,479	3,762	2,762	3,196	2,210	3,862	3,525	4,197	3,862	4,177	3,065	3,548	2,452
90	3,514	3,208	3,817	3,518	3,800	2,818	3,231	2,254	3,902	3,560	4,239	3,904	4,219	3,126	3,586	2,501
91	3,550	3,239	3,858	3,554	3,838	2,873	3,266	2,298	3,940	3,595	4,281	3,946	4,260	3,188	3,624	2,550
92	3,585	3,272	3,896	3,593	3,876	2,932	3,300	2,346	3,980	3,632	4,323	3,987	4,302	3,253	3,665	2,602
93	3,621	3,304	3,934	3,632	3,917	2,990	3,337	2,393	4,019	3,669	4,367	4,030	4,345	3,317	3,703	2,653
94	3,659	3,337	3,973	3,671	3,954	3,050	3,373	2,441	4,060	3,704	4,410	4,075	4,390	3,384	3,742	2,708
95	3,695	3,372	4,014	3,711	3,994	3,111	3,408	2,490	4,100	3,741	4,454	4,118	4,432	3,451	3,784	2,762
96	3,731	3,404	4,054	3,750	4,033	3,173	3,445	2,539	4,141	3,779	4,498	4,162	4,476	3,521	3,824	2,816
97	3,768	3,439	4,094	3,791	4,075	3,236	3,482	2,590	4,182	3,817	4,543	4,207	4,523	3,591	3,864	2,872
98	3,806	3,473	4,135	3,831	4,115	3,301	3,520	2,641	4,225	3,857	4,590	4,251	4,566	3,663	3,906	2,930
99	3,844	3,509	4,177	3,871	4,156	3,367	3,556	2,694	4,266	3,894	4,635	4,298	4,613	3,736	3,947	2,988

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

Semi Annual 1/2	Quarterly 1/4	Monthly 1/12
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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 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	5,920	N/A	N/A	N/A	N/A	N/A	N/A	N/A	6,573	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	1,617	1,475	1,757	1,518	1,748	1,286	1,396	1,028	1,795	1,637	1,950	1,686	1,939	1,429	1,549	1,142
66	1,617	1,475	1,757	1,518	1,748	1,286	1,396	1,028	1,795	1,637	1,950	1,686	1,939	1,429	1,549	1,142
67	1,617	1,475	1,757	1,518	1,748	1,286	1,396	1,028	1,795	1,637	1,950	1,686	1,939	1,429	1,549	1,142
68	1,690	1,542	1,836	1,597	1,826	1,334	1,467	1,067	1,877	1,711	2,038	1,771	2,027	1,483	1,629	1,186
69	1,759	1,605	1,909	1,669	1,899	1,379	1,534	1,104	1,951	1,780	2,119	1,853	2,109	1,534	1,702	1,226
70	1,827	1,667	1,987	1,745	1,975	1,429	1,602	1,142	2,028	1,852	2,203	1,936	2,193	1,585	1,779	1,268
71	1,900	1,733	2,065	1,823	2,055	1,483	1,676	1,186	2,109	1,925	2,291	2,024	2,281	1,645	1,859	1,316
72	1,977	1,804	2,147	1,905	2,137	1,538	1,751	1,231	2,194	2,002	2,383	2,115	2,372	1,707	1,943	1,365
73	2,037	1,858	2,213	1,969	2,201	1,581	1,810	1,266	2,260	2,061	2,456	2,187	2,441	1,757	2,009	1,406
74	2,097	1,913	2,279	2,035	2,267	1,628	1,870	1,301	2,327	2,124	2,529	2,258	2,516	1,804	2,076	1,443
75	2,161	1,970	2,346	2,103	2,335	1,673	1,932	1,338	2,399	2,189	2,604	2,335	2,593	1,857	2,145	1,486
76	2,225	2,030	2,417	2,173	2,405	1,718	1,996	1,374	2,471	2,254	2,683	2,412	2,669	1,905	2,215	1,524
77	2,292	2,090	2,490	2,246	2,478	1,763	2,062	1,410	2,545	2,321	2,763	2,492	2,750	1,956	2,289	1,565
78	2,361	2,155	2,565	2,318	2,551	1,808	2,129	1,446	2,620	2,391	2,847	2,573	2,832	2,009	2,366	1,606
79	2,432	2,218	2,640	2,395	2,628	1,856	2,201	1,485	2,699	2,462	2,931	2,659	2,917	2,060	2,441	1,648
80	2,504	2,285	2,720	2,473	2,706	1,907	2,272	1,525	2,778	2,537	3,020	2,746	3,005	2,116	2,522	1,692
81	2,567	2,342	2,788	2,540	2,775	1,957	2,335	1,567	2,849	2,601	3,095	2,820	3,079	2,173	2,592	1,739
82	2,617	2,389	2,844	2,596	2,830	1,999	2,384	1,600	2,906	2,652	3,156	2,882	3,141	2,218	2,648	1,775
83	2,670	2,437	2,900	2,652	2,887	2,042	2,437	1,633	2,964	2,704	3,220	2,945	3,205	2,268	2,705	1,814
84	2,724	2,485	2,959	2,710	2,945	2,087	2,490	1,668	3,023	2,759	3,284	3,008	3,268	2,316	2,764	1,854
85	2,765	2,523	3,004	2,754	2,988	2,120	2,531	1,696	3,069	2,801	3,334	3,056	3,317	2,352	2,808	1,882
86	2,806	2,560	3,048	2,798	3,034	2,161	2,571	1,730	3,115	2,843	3,384	3,107	3,367	2,400	2,854	1,921
87	2,834	2,586	3,078	2,829	3,064	2,205	2,599	1,764	3,147	2,871	3,418	3,140	3,400	2,448	2,885	1,958
88	2,863	2,612	3,110	2,860	3,095	2,248	2,627	1,799	3,179	2,899	3,452	3,174	3,434	2,497	2,917	1,998
89	2,891	2,638	3,140	2,892	3,126	2,293	2,656	1,834	3,210	2,928	3,486	3,209	3,470	2,546	2,948	2,037
90	2,920	2,665	3,172	2,922	3,156	2,340	2,684	1,871	3,242	2,959	3,521	3,244	3,504	2,598	2,979	2,079
91	2,949	2,692	3,204	2,953	3,188	2,385	2,713	1,909	3,274	2,987	3,555	3,278	3,540	2,650	3,011	2,120
92	2,980	2,719	3,235	2,985	3,220	2,434	2,741	1,946	3,307	3,018	3,591	3,314	3,575	2,702	3,043	2,161
93	3,008	2,746	3,268	3,018	3,252	2,482	2,771	1,987	3,340	3,048	3,627	3,347	3,609	2,758	3,076	2,206
94	3,039	2,773	3,301	3,049	3,284	2,534	2,801	2,025	3,373	3,078	3,664	3,385	3,646	2,811	3,110	2,248
95	3,069	2,801	3,334	3,082	3,317	2,583	2,831	2,066	3,407	3,109	3,700	3,421	3,682	2,869	3,143	2,295
96	3,100	2,829	3,367	3,115	3,351	2,635	2,862	2,109	3,440	3,140	3,737	3,457	3,719	2,926	3,177	2,340
97	3,130	2,858	3,400	3,150	3,384	2,687	2,893	2,150	3,475	3,171	3,775	3,495	3,756	2,984	3,210	2,386
98	3,161	2,886	3,434	3,184	3,418	2,740	2,923	2,192	3,509	3,202	3,812	3,533	3,794	3,044	3,244	2,436
99	3,193	2,915	3,470	3,217	3,452	2,796	2,955	2,237	3,545	3,235	3,851	3,570	3,832	3,104	3,280	2,483

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

Semi Annual
1/2

Quarterly
1/4

Monthly
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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1316 All but \$329 a day All but \$658 a day \$0 \$0	\$0 \$329 a day \$658 a day 100% of Medicare eligible expenses \$0	\$1316 (Part A deductible) \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$164.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$164.50 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 \$183 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 \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (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 \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (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 \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1316 All but \$329 a day All but \$658 a day \$0 \$0	\$1316 (Part A deductible) \$329 a day \$658 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$164.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$164.50 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 \$183 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 \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$183 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$183 (Part B deductible) \$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 — Durable medical equipment First \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$183 (Part B deductible) \$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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1316 All but \$329 a day All but \$658 a day \$0 \$0	\$1316 (Part A deductible) \$329 a day \$658 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$164.50 a day \$0	\$0 Up to \$164.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 \$183 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 \$183 of Medicare Approved Amounts*	\$0	\$183 (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 \$183 of Medicare Approved Amounts*	\$0	\$183 (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 \$183 of Medicare Approved Amounts*	\$0	\$183 (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 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.
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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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1316 All but \$329 a day All but \$658 a day \$0 \$0	\$1316 (Part A deductible) \$329 a day \$658 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$164.50 a day \$0	\$0 Up to \$164.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 \$183 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 \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (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 \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (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 \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1316 All but \$329 a day All but \$658 a day \$0 \$0	\$1316 (Part A deductible) \$329 a day \$658 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$164.50 a day \$0	\$0 Up to \$164.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 \$183 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 \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$183 (Part B deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$183 of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 \$0 80%	All costs \$183 (Part B deductible) 20%	\$0 \$0 \$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 — Durable medical equipment First \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$183 (Part B deductible) 20%	\$0 \$0 \$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 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

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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1316 All but \$329 a day All but \$658 a day \$0 \$0	\$1316 (Part A deductible) \$329 a day \$658 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$164.50 a day \$0	\$0 Up to \$164.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 \$183 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 \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$183 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	0%
BLOOD First 3 pints Next \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$183 (Part B deductible) \$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 — Durable medical equipment First \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$183 (Part B deductible) \$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>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</p>	<p>\$0 \$0</p>	<p>\$0 80% to a lifetime maximum benefit of \$50,000.</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>

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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1316 All but \$329 a day All but \$658 a day \$0 \$0	\$658 (50% Part A deductible) \$329 a day \$658 a day 100% of Medicare eligible expenses \$0	\$658 (50% Part A deductible) \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$164.50 a day \$0	\$0 Up to \$164.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 \$183 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 \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$183 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$183 (Part B deductible) \$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 — Durable medical equipment First \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$183 (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.

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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1316 All but \$329 a day All but \$658 a day \$0 \$0	\$1316 (Part A deductible) \$329 a day \$658 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$164.50 a day \$0	\$0 Up to \$164.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 \$183 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 \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The co-payment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$183 (Part B deductible) Up to \$20 per office visit and up to \$50 per emergency room visit. The co-payment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$183 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN N
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment First \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (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.