

THE MANHATTAN LIFE INSURANCE COMPANY
P.O. Box 925568, Houston, Texas 77292-5568
OUTLINE OF MEDICARE SUPPLEMENT INSURANCE

MEDICARE SUPPLEMENT INSURANCE

The Wisconsin Insurance Commissioner has set standards for Medicare supplement insurance. This policy meets those standards. It, along with Medicare, may not cover all of your medical costs. You should review carefully all certificate limitations. For an explanation of these standards and other important information, see “Wisconsin Guide to Health Insurance for People with Medicare,” given to you when you applied for this policy. Do not buy this policy if you did not get this guide.

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, state and zip code of residence.

Premiums are based on your attained age and will change on Your Policy Anniversary Date.

RENEWABILITY

Your policy is guaranteed renewable and is subject to premium rate changes by class, based on attained age, sex, smoker/non-smoker, and state and zip code of residence of the insured. We will not cancel or non-renew this contract for any reason other than the nonpayment of premium or material misrepresentation.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy’s most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to our 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 directly to you.

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.

USUAL, CUSTOMARY, AND REASONABLE CHARGES (UCR)

This policy limits covered expenses to the usual, customary, and reasonable charge for services, in which usual and customary refer only to mandated benefits. We settle claims based on a specific methodology and the eligible amount of a claim may be less than the provider's billed charge. A usual charge is the actual charge by a provider for a given service. A charge is customary when it is within a range (as determined by the carrier) of usual charges billed by most physicians or other professional providers. A charge is reasonable when it meets the usual or customary criteria, whichever is less, or it may be reasonable if, in the opinion of an appropriate medical/surgical review committee of the carrier, it merits special consideration based on the nature and extent of treatment of the particular case.

**THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL PREFERRED PREMIUM RATES
FOR USE IN WISCONSIN ZIP CODES**

Attained Age	530-534													
	Base Plan		Base Plan Part B Copay		Part A Ded Rider		Part B Ded Rider		Part B Excess Rider		Additional Home Care Rider		Foreign Travel Rider	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-64	5,541	6,371	4,449	5,117	1,003	1,154	198	198	73	85	80	93	49	58
65	1,847	2,123	1,483	1,706	334	385	198	198	26	29	28	31	17	20
66	1,847	2,123	1,483	1,706	334	385	198	198	26	29	28	31	17	20
67	1,847	2,123	1,483	1,706	334	385	198	198	26	29	28	31	17	20
68	1,928	2,217	1,547	1,778	350	402	198	198	27	30	29	33	17	20
69	2,011	2,311	1,611	1,852	366	421	198	198	28	31	30	33	19	20
70	2,091	2,405	1,674	1,924	378	434	198	198	28	31	30	34	19	20
71	2,163	2,488	1,731	1,990	396	456	198	198	29	33	31	35	20	22
72	2,234	2,569	1,788	2,055	416	478	198	198	30	33	33	37	20	22
73	2,305	2,652	1,845	2,120	433	498	198	198	30	34	33	37	20	24
74	2,376	2,732	1,903	2,186	451	519	198	198	31	35	33	38	20	26
75	2,451	2,818	1,961	2,255	472	542	198	198	33	35	34	41	22	26
76	2,523	2,901	2,020	2,324	493	565	198	198	33	37	35	42	22	27
77	2,595	2,984	2,080	2,393	516	592	198	198	33	38	37	43	24	27
78	2,671	3,073	2,146	2,465	540	621	198	198	34	41	37	44	24	28
79	2,749	3,161	2,209	2,540	564	650	198	198	35	42	38	45	26	28
80	2,828	3,252	2,275	2,616	590	679	198	198	35	43	41	46	26	29
81	2,914	3,350	2,345	2,698	615	707	198	198	37	43	42	47	26	29
82	2,997	3,447	2,422	2,785	640	736	198	198	38	44	43	47	27	30
83	3,088	3,551	2,498	2,874	668	767	198	198	38	45	43	49	27	30
84	3,180	3,658	2,580	2,965	693	798	198	198	41	46	44	51	28	31
85	3,275	3,765	2,660	3,059	721	831	198	198	42	47	45	52	28	33
86	3,373	3,881	2,746	3,159	747	857	198	198	43	47	46	54	29	33
87	3,476	3,997	2,835	3,261	770	886	198	198	43	49	47	56	29	33
88	3,581	4,118	2,926	3,366	797	915	198	198	44	51	49	57	30	33
89	3,682	4,234	3,014	3,465	821	944	198	198	45	52	49	58	30	34
90	3,780	4,348	3,101	3,566	846	972	198	198	46	54	51	59	31	35
91	3,873	4,454	3,182	3,660	869	998	198	198	46	56	52	60	31	35
92	3,960	4,554	3,261	3,749	886	1,020	198	198	47	56	52	60	33	35
93	4,042	4,647	3,334	3,832	907	1,042	198	198	47	57	54	61	33	37
94	4,123	4,741	3,406	3,916	925	1,064	198	198	49	57	54	62	33	37
95	4,207	4,837	3,480	4,003	944	1,085	198	198	49	58	56	62	33	37
96	4,290	4,935	3,551	4,084	964	1,108	198	198	51	59	57	63	33	38
97	4,378	5,034	3,622	4,164	983	1,129	198	198	52	60	58	64	34	41
98	4,464	5,134	3,695	4,248	1,003	1,154	198	198	52	61	58	66	34	41
99	4,553	5,236	3,767	4,334	1,024	1,175	198	198	54	61	59	67	35	42

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

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

A discount factor of .88 is applied for household discount applicants
There is a one-time \$25.00 policy fee.

**THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL STANDARD PREMIUM RATES
FOR USE IN WISCONSIN ZIP CODES**

530-534

Attained Age	Base Plan		Base Plan Part B Copay		Part A Ded Rider		Part B Ded Rider		Part B Excess Rider		Additional Home Care		Foreign Travel Rider	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-64	6,371	7,328	5,117	5,884	1,154	1,326	198	198	85	98	93	106	58	64
65	2,123	2,443	1,706	1,961	385	443	198	198	29	33	31	34	20	22
66	2,123	2,443	1,706	1,961	385	443	198	198	29	33	31	34	20	22
67	2,123	2,443	1,706	1,961	385	443	198	198	29	33	31	34	20	22
68	2,217	2,551	1,778	2,046	402	463	198	198	30	33	33	37	20	22
69	2,311	2,660	1,852	2,131	421	485	198	198	31	34	33	38	20	24
70	2,405	2,766	1,924	2,212	434	499	198	198	31	35	34	41	20	26
71	2,488	2,860	1,990	2,290	456	525	198	198	33	37	35	42	22	26
72	2,569	2,954	2,055	2,366	478	549	198	198	33	38	37	43	22	27
73	2,652	3,049	2,120	2,439	498	575	198	198	34	41	37	44	24	28
74	2,732	3,144	2,186	2,516	519	596	198	198	35	42	38	45	26	28
75	2,818	3,241	2,255	2,594	542	621	198	198	35	43	41	46	26	29
76	2,901	3,336	2,324	2,671	565	653	198	198	37	44	42	47	27	30
77	2,984	3,432	2,393	2,752	592	683	198	198	38	45	43	49	27	30
78	3,073	3,534	2,465	2,836	621	715	198	198	41	46	44	51	28	31
79	3,161	3,636	2,540	2,920	650	748	198	198	42	47	45	52	28	31
80	3,252	3,740	2,616	3,008	679	779	198	198	43	49	46	54	29	33
81	3,350	3,852	2,698	3,103	707	812	198	198	43	49	47	56	29	33
82	3,447	3,965	2,785	3,202	736	846	198	198	44	51	47	57	30	33
83	3,551	4,085	2,874	3,306	767	883	198	198	45	52	49	58	30	34
84	3,658	4,206	2,965	3,410	798	918	198	198	46	54	51	59	31	35
85	3,765	4,329	3,059	3,519	831	954	198	198	47	56	52	60	33	35
86	3,881	4,462	3,159	3,634	857	986	198	198	47	57	54	61	33	37
87	3,997	4,597	3,261	3,750	886	1,019	198	198	49	58	56	62	33	38
88	4,118	4,736	3,366	3,870	915	1,054	198	198	51	59	57	64	33	38
89	4,234	4,869	3,465	3,986	944	1,085	198	198	52	60	58	66	34	41
90	4,348	5,000	3,566	4,099	972	1,118	198	198	54	61	59	67	35	42
91	4,454	5,122	3,660	4,209	998	1,147	198	198	56	62	60	69	35	42
92	4,554	5,238	3,749	4,311	1,020	1,174	198	198	56	63	60	69	35	43
93	4,647	5,346	3,832	4,407	1,042	1,199	198	198	57	63	61	70	37	43
94	4,741	5,454	3,916	4,505	1,064	1,224	198	198	57	64	62	72	37	43
95	4,837	5,563	4,003	4,604	1,085	1,250	198	198	58	64	62	72	37	44
96	4,935	5,675	4,084	4,697	1,108	1,274	198	198	59	66	63	73	38	45
97	5,034	5,788	4,164	4,790	1,129	1,299	198	198	60	67	64	75	41	45
98	5,134	5,905	4,248	4,885	1,154	1,326	198	198	61	70	66	76	41	46
99	5,236	6,023	4,334	4,984	1,175	1,353	198	198	61	72	67	77	42	47

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

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

A discount factor of .88 is applied for household discount applicants

There is a one-time \$25.00 policy fee.

**THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL PREFERRED PREMIUM RATES
FOR USE IN WISCONSIN ZIP CODES**

535-549

Attained Age	Base Plan		Base Plan Part B Copay		Part A Ded Rider		Part B Ded Rider		Part B Excess Rider		Additional Home Care		Foreign Travel Rider	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-64	4,707	5,412	3,779	4,347	852	980	198	198	62	72	68	79	42	49
65	1,569	1,804	1,260	1,449	284	327	198	198	22	24	24	26	14	17
66	1,569	1,804	1,260	1,449	284	327	198	198	22	24	24	26	14	17
67	1,569	1,804	1,260	1,449	284	327	198	198	22	24	24	26	14	17
68	1,638	1,883	1,314	1,510	297	341	198	198	23	25	24	28	14	17
69	1,708	1,963	1,368	1,573	311	358	198	198	24	26	25	28	16	17
70	1,776	2,043	1,422	1,635	321	369	198	198	24	26	25	29	16	17
71	1,838	2,113	1,470	1,691	337	387	198	198	24	28	26	30	17	19
72	1,898	2,182	1,519	1,746	353	406	198	198	25	28	28	32	17	19
73	1,958	2,253	1,567	1,801	368	423	198	198	25	29	28	32	17	21
74	2,018	2,321	1,616	1,857	383	441	198	198	26	30	28	32	17	22
75	2,082	2,394	1,666	1,916	401	461	198	198	28	30	29	35	19	22
76	2,143	2,464	1,716	1,974	419	480	198	198	28	32	30	36	19	23
77	2,204	2,535	1,767	2,033	438	503	198	198	28	32	32	36	21	23
78	2,269	2,610	1,823	2,094	459	528	198	198	29	35	32	37	21	24
79	2,335	2,685	1,876	2,157	479	552	198	198	30	36	32	38	22	24
80	2,402	2,763	1,932	2,222	501	577	198	198	30	36	35	39	22	24
81	2,475	2,846	1,992	2,292	522	600	198	198	32	36	36	40	22	24
82	2,546	2,928	2,057	2,366	544	625	198	198	32	37	36	40	23	25
83	2,623	3,016	2,122	2,441	567	652	198	198	32	38	36	42	23	25
84	2,701	3,107	2,191	2,519	589	678	198	198	35	39	37	43	24	26
85	2,782	3,198	2,259	2,598	612	706	198	198	36	40	38	44	24	28
86	2,865	3,297	2,333	2,684	634	728	198	198	36	40	39	46	24	28
87	2,953	3,395	2,408	2,770	654	753	198	198	36	42	40	47	24	28
88	3,042	3,498	2,485	2,859	677	777	198	198	37	43	42	48	25	28
89	3,128	3,597	2,560	2,944	698	802	198	198	38	44	42	49	25	29
90	3,211	3,693	2,634	3,029	719	826	198	198	39	46	43	50	26	30
91	3,290	3,783	2,703	3,109	738	848	198	198	39	47	44	51	26	30
92	3,364	3,869	2,770	3,184	753	867	198	198	40	47	44	51	28	30
93	3,433	3,948	2,832	3,255	770	885	198	198	40	48	46	52	28	32
94	3,502	4,027	2,893	3,327	786	904	198	198	42	48	46	53	28	32
95	3,574	4,109	2,956	3,400	802	922	198	198	42	49	47	53	28	32
96	3,644	4,192	3,016	3,469	819	941	198	198	43	50	48	54	28	32
97	3,719	4,276	3,077	3,537	835	959	198	198	44	51	49	55	29	35
98	3,792	4,361	3,139	3,609	852	980	198	198	44	52	49	56	29	35
99	3,868	4,448	3,200	3,681	870	998	198	198	46	52	50	57	30	36

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

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

A discount factor of .88 is applied for household discount applicants
There is a one-time \$25 policy fee.

**THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL STANDARD PREMIUM RATES
FOR USE IN WISCONSIN ZIP CODES
535-549**

Attained Age	Base Plan		Base Plan Part B Copay		Part A Ded Rider		Part B Ded Rider		Part B Excess Rider		Additional Home Care		Foreign Travel Rider	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-64	5,412	6,225	4,347	4,998	980	1,127	198	198	72	83	79	90	49	55
65	1,804	2,075	1,449	1,666	327	376	198	198	24	28	26	29	17	19
66	1,804	2,075	1,449	1,666	327	376	198	198	24	28	26	29	17	19
67	1,804	2,075	1,449	1,666	327	376	198	198	24	28	26	29	17	19
68	1,883	2,167	1,510	1,738	341	393	198	198	25	28	28	32	17	19
69	1,963	2,259	1,573	1,810	358	412	198	198	26	29	28	32	17	21
70	2,043	2,349	1,635	1,879	369	424	198	198	26	30	29	35	17	22
71	2,113	2,429	1,691	1,945	387	446	198	198	28	32	30	36	19	22
72	2,182	2,509	1,746	2,010	406	466	198	198	28	32	32	36	19	23
73	2,253	2,590	1,801	2,072	423	488	198	198	29	35	32	37	21	24
74	2,321	2,671	1,857	2,137	441	506	198	198	30	36	32	38	22	24
75	2,394	2,753	1,916	2,203	461	528	198	198	30	36	35	39	22	24
76	2,464	2,834	1,974	2,269	480	555	198	198	32	37	36	40	23	25
77	2,535	2,915	2,033	2,338	503	580	198	198	32	38	36	42	23	25
78	2,610	3,002	2,094	2,409	528	608	198	198	35	39	37	43	24	26
79	2,685	3,089	2,157	2,481	552	635	198	198	36	40	38	44	24	26
80	2,763	3,177	2,222	2,555	577	662	198	198	36	42	39	46	24	28
81	2,846	3,272	2,292	2,636	600	690	198	198	36	42	40	47	24	28
82	2,928	3,368	2,366	2,720	625	719	198	198	37	43	40	48	25	28
83	3,016	3,470	2,441	2,808	652	750	198	198	38	44	42	49	25	29
84	3,107	3,573	2,519	2,897	678	780	198	198	39	46	43	50	26	30
85	3,198	3,677	2,598	2,989	706	811	198	198	40	47	44	51	28	30
86	3,297	3,790	2,684	3,087	728	837	198	198	40	48	46	52	28	32
87	3,395	3,905	2,770	3,185	753	866	198	198	42	49	47	53	28	32
88	3,498	4,023	2,859	3,287	777	895	198	198	43	50	48	55	28	32
89	3,597	4,136	2,944	3,386	802	922	198	198	44	51	49	56	29	35
90	3,693	4,247	3,029	3,482	826	950	198	198	46	52	50	57	30	36
91	3,783	4,351	3,109	3,576	848	974	198	198	47	53	51	58	30	36
92	3,869	4,449	3,184	3,662	867	997	198	198	47	54	51	58	30	36
93	3,948	4,541	3,255	3,744	885	1,018	198	198	48	54	52	59	32	36
94	4,027	4,633	3,327	3,827	904	1,040	198	198	48	55	53	61	32	36
95	4,109	4,726	3,400	3,911	922	1,062	198	198	49	55	53	61	32	37
96	4,192	4,821	3,469	3,990	941	1,082	198	198	50	56	54	62	32	38
97	4,276	4,917	3,537	4,069	959	1,104	198	198	51	57	55	64	35	38
98	4,361	5,016	3,609	4,150	980	1,127	198	198	52	59	56	65	35	39
99	4,448	5,116	3,681	4,234	998	1,149	198	198	52	61	57	66	36	40

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

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

A discount factor of .88 is applied for household discount applicants
There is a one-time \$25 policy fee.

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	PER BENEFIT PERIOD	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but \$1408	\$0 OR <input type="checkbox"/> OPTIONAL PART A DEDUCTIBLE RIDER*	\$1408 OR \$0
	61 st to 90 th days	All but \$352 per day	\$352 per day	\$0
	91 st day and after while using 60 lifetime reserve days	All but \$704 per day	\$704 a day	\$0
	Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare Eligible Expenses**	
	Beyond the additional 365 days	\$0	\$0	
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
	21 st through 100 th day	All but \$176 per day	Up to \$176 a day \$0	\$0
	101 st day and after	\$0		All costs
INPATIENT PSYCHIATRIC CARE In patient psychiatric care in a participating psychiatric hospital		190 days per lifetime	175 additional days per lifetime	All costs that exceed the lifetime maximum
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 copayment or coinsurance for outpatient drugs and inpatient respite care	Medicare Copayment or coinsurance	\$0

***These are optional riders. You purchased this benefit if the box is checked and you paid the premium.**

**** NOTICE: When your Medicare Part A hospital benefits are exhausted, we, the insurer, stands in place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits".**

MEDICARE SUPPLEMENT POLICIES – PART B BENEFITS

SERVICES	PER CALENDAR YEAR	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
MEDICAL EXPENSES Eligible expenses for physician’s services, in-patient and out-patient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	First \$198 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 OR <input type="checkbox"/> OPTIONAL PART B DEDUCTIBLE RIDER** Generally 20%; OR <input type="checkbox"/> OPTIONAL PART B EXCESS CHARGES RIDER**	\$198 (Part B Deductible) OR \$0 Charges that exceed Medicare Eligible Expenses OR \$0
BLOOD	First 3 pints Next \$198 of Medicare approved amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$198 Part B deductible 20%	\$0
CLINICAL LABORATORY SERVICES – Tests for diagnostic services		100%	\$0	\$0
HOME HEALTH CARE		100% of charges for visits considered medically necessary by Medicare	40 visits, OR <input type="checkbox"/> OPTIONAL ADDITIONAL HOME HEALTH CARE RIDER**	All expenses beyond 40 visits per year OR All expenses beyond 365 visits per year.
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the 60 days of each trip outside the USA	First \$250 each calendar year Remainder of charges	\$0	\$250	20% and amounts over the \$50,000 lifetime maximum 80% to a lifetime maximum benefit of \$50,000
PREVENTIVE MEDICAL CARE BENEFIT –NOT COVERED BY MEDICARE. Some annual physical and preventive tests and services	First \$120 each calendar year Additional charges	\$0 \$0	\$120 \$0	\$0 All Costs

administered or ordered by your doctor when not covered by Medicare				
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***Once you have been billed \$198 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.**

****These are optional riders. You purchased this benefit if the box is checked and you paid the premium.**

LIMITATIONS AND EXCLUSIONS

- Nursing home care costs beyond what is covered by Medicare and the 30-day skilled nursing care, which includes physical or occupational therapy, speech language pathology or respiratory care.
- Physician charges above Medicare’s approved charge.
- Outpatient prescription drugs.
- Most care received outside of the United State of America.
- Dental care, dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for and the cost of eyeglasses or hearing aids, unless eligible under Medicare.
- Coverage for emergency care anywhere or for care received outside the service area if this care is treated differently than other covered benefits.
- Usual, customary, and reasonable (UCR) limitations, in which usual and customary charges apply only to mandated benefits.

The outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult “Medicare & You” for more details.

The policy is guaranteed renewable as long as you live, provided you continue to pay the premiums when due. The premium may change if a new table of rates is applicable to the policy.

MEDICARE SUPPLEMENT PREMIUM INFORMATION

ANNUAL PREMIUM

\$ _____

BASIC MEDICARE SUPPLEMENT COVERAGE

OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT POLICY

Each of these riders may be purchased separately.

\$ _____

Rider A - Medicare Part A deductible

100% of Part A deductible.

\$ _____

Rider B – Additional Home Health Care

Coverage for Home Health Care visits shall, when combined with coverage under Parts A and B of Medicare, produce an aggregate coverage of 365 Home Care visits per Calendar Year subject to all of the terms and conditions stated in the policy.

\$ _____

RIDER C IS AVAILABLE ONLY TO THOSE FIRST ELIGIBLE FOR MEDICARE BEFORE JANUARY 1, 2020:

Rider C – Medicare Part B deductible

100% of Part B deductible. **Rider 2 - Medicare 50% Part A deductible**
50% of Part A deductible.

\$ _____

Rider D– Medicare Part B Copayment or Coinsurance Rider

Copayment or coinsurance will be the lesser of \$20 per office visit or the Medicare Part B coinsurance and the lesser of \$50 per emergency room visit or the Medicare Part B coinsurance in addition to Part B deductible.

B deductible.

\$ _____

Rider E – Medicare Part B Excess Charges Rider

Covers difference between eligible charge and limiting charge.

\$ _____

Rider F – Foreign Travel Emergency Rider

After a \$250 deductible, covers at least 80% of expenses associated with emergency medical care received outside the U.S.A. during the first 60 days of a trip with a lifetime maximum of \$50,000.

\$ _____

TOTAL FOR BASIC POLICY AND SELECTED OPTIONAL BENEFITS

(NOTE: The soliciting agent will enter the appropriate premium amounts and the total at the time this outline is given to the applicant.)

IN ADDITION TO THIS OUTLINE OF COVERAGE, THE MANHATTAN LIFE INSURANCE COMPANY WILL SEND YOU AN ANNUAL NOTICE TO YOU 30 DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE CHANGES AND WILL DESCRIBE THESE CHANGES AND THE CHANGES IN YOUR MEDICARE SUPPLEMENT COVERAGE.

**SUMMARY OF ADDITIONAL COVERAGE REQUIRED BY
APPLICABLE WISCONSIN LAWS**

SKILLED NURSING FACILITY CARE

Thirty (30) days of skilled nursing care in a Skilled Nursing Facility. The facility does not need to be certified by Medicare and the stay does not have to meet Medicare's definition of skilled care. No prior hospitalization is required.

KIDNEY DISEASE

Inpatient and outpatient expense for dialysis, transplantation, or donor-related services of kidney disease up to \$30,000 in any calendar year.

CHIROPRACTOR

The usual and customary expense for services provided by a chiropractor, even if Medicare does not cover the claim.

DIABETES (NONPRESCRIPTION)

Coverage for the usual and customary expenses incurred for costs of non-prescription insulin or any other non-prescription equipment and supplies for the treatment of diabetes. This does not include any other outpatient non-prescription or prescription medications. This benefit will not duplicate expenses paid by Medicare.

PREVENTATIVE HEALTH CARE SERVICES

Coverage for preventive health care services not covered by Medicare and as determined to be medically appropriate by an attending Physician. Reimbursement shall be for the actual charges up to \$120 per calendar year. This benefit will not duplicate expenses paid by Medicare.

HOSPITAL AND AMBULATORY SURGERY CENTER & ANESTHESIA CHARGES FOR DENTAL CARE

This benefit is limited to specific conditions and circumstances.

BREAST RECONSTRUCTION POST MASTECTOMY

Coverage of breast reconstruction of the affected issue incident to a mastectomy.