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 fourteen 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 including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic , including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic , 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 Premium Rates
FOR USE IN MISSOURI ZIP CODES
630, 631, 633, 640, 641

Issue	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	2,283	2,292	2,945	2,601	2,869	2,320	2,425	1,856	2,567	2,578	3,314	2,926	3,228	2,609	2,728	2,087
65	1,776	1,777	2,277	2,007	2,217	1,789	1,868	1,432	1,996	1,999	2,560	2,257	2,494	2,014	2,101	1,611
66	1,776	1,777	2,277	2,007	2,217	1,789	1,868	1,432	1,996	1,999	2,560	2,257	2,494	2,014	2,101	1,611
67	1,776	1,777	2,277	2,007	2,217	1,789	1,868	1,432	1,996	1,999	2,560	2,257	2,494	2,014	2,101	1,611
68	1,833	1,834	2,352	2,073	2,290	1,841	1,931	1,473	2,061	2,062	2,645	2,333	2,577	2,070	2,172	1,656
69	1,889	1,891	2,428	2,142	2,366	1,894	1,996	1,516	2,124	2,128	2,731	2,409	2,660	2,130	2,245	1,704
70	1,941	1,947	2,502	2,209	2,438	1,946	2,059	1,557	2,183	2,191	2,816	2,484	2,743	2,190	2,316	1,751
71	1,993	2,001	2,576	2,274	2,508	1,980	2,119	1,585	2,241	2,252	2,897	2,556	2,822	2,229	2,385	1,783
72	2,046	2,055	2,645	2,336	2,577	2,015	2,179	1,612	2,300	2,312	2,974	2,627	2,898	2,267	2,451	1,814
73	2,131	2,140	2,755	2,433	2,684	2,067	2,270	1,654	2,397	2,408	3,099	2,737	3,019	2,325	2,554	1,861
74	2,221	2,231	2,872	2,535	2,796	2,122	2,366	1,697	2,499	2,509	3,229	2,852	3,145	2,387	2,661	1,910
75	2,314	2,325	2,993	2,643	2,915	2,180	2,467	1,745	2,604	2,616	3,366	2,973	3,280	2,453	2,774	1,962
76	2,379	2,389	3,075	2,715	2,996	2,216	2,533	1,773	2,676	2,688	3,459	3,056	3,370	2,494	2,850	1,995
77	2,444	2,456	3,160	2,791	3,079	2,254	2,605	1,803	2,751	2,762	3,555	3,141	3,463	2,536	2,929	2,029
78	2,514	2,525	3,250	2,869	3,165	2,293	2,677	1,834	2,828	2,841	3,656	3,228	3,560	2,579	3,012	2,063
79	2,584	2,597	3,341	2,951	3,255	2,333	2,753	1,866	2,907	2,921	3,759	3,320	3,660	2,625	3,097	2,100
80	2,659	2,670	3,436	3,036	3,348	2,376	2,831	1,901	2,990	3,005	3,866	3,414	3,765	2,673	3,186	2,138
81	2,736	2,747	3,536	3,123	3,444	2,402	2,913	1,922	3,076	3,091	3,978	3,513	3,874	2,703	3,278	2,162
82	2,815	2,828	3,639	3,214	3,545	2,430	2,998	1,944	3,166	3,181	4,094	3,616	3,987	2,734	3,373	2,187
83	2,897	2,912	3,746	3,309	3,649	2,459	3,087	1,967	3,259	3,274	4,214	3,721	4,106	2,765	3,472	2,211
84	2,983	2,997	3,857	3,407	3,757	2,487	3,179	1,990	3,356	3,372	4,339	3,832	4,225	2,798	3,575	2,238
85	3,073	3,087	3,971	3,509	3,869	2,519	3,273	2,015	3,457	3,472	4,468	3,946	4,353	2,832	3,681	2,266
86	3,165	3,180	4,093	3,614	3,986	2,569	3,372	2,055	3,559	3,577	4,602	4,065	4,484	2,889	3,793	2,312
87	3,261	3,276	4,216	3,724	4,108	2,621	3,474	2,096	3,669	3,686	4,743	4,188	4,620	2,947	3,908	2,358
88	3,360	3,378	4,346	3,838	4,233	2,673	3,580	2,138	3,780	3,798	4,888	4,317	4,761	3,006	4,027	2,405
89	3,465	3,481	4,479	3,956	4,363	2,727	3,690	2,182	3,897	3,916	5,039	4,451	4,908	3,066	4,153	2,453
90	3,574	3,589	4,620	4,080	4,500	2,781	3,807	2,224	4,019	4,038	5,196	4,590	5,061	3,128	4,281	2,502
91	3,685	3,703	4,763	4,208	4,641	2,836	3,926	2,269	4,145	4,165	5,359	4,733	5,221	3,190	4,416	2,552
92	3,802	3,820	4,915	4,341	4,787	2,893	4,050	2,315	4,277	4,296	5,529	4,884	5,385	3,255	4,556	2,604
93	3,924	3,941	5,072	4,479	4,942	2,951	4,180	2,361	4,414	4,434	5,705	5,039	5,558	3,319	4,701	2,655
94	4,049	4,069	5,236	4,623	5,099	3,010	4,315	2,408	4,555	4,577	5,889	5,201	5,736	3,386	4,853	2,708
95	4,181	4,201	5,405	4,775	5,266	3,071	4,455	2,456	4,704	4,725	6,081	5,369	5,924	3,453	5,011	2,762
96	4,318	4,339	5,583	4,930	5,437	3,131	4,600	2,505	4,856	4,879	6,280	5,545	6,117	3,522	5,175	2,818
97	4,460	4,482	5,767	5,093	5,618	3,195	4,752	2,555	5,017	5,040	6,486	5,729	6,318	3,593	5,345	2,874
98	4,608	4,630	5,958	5,262	5,803	3,258	4,909	2,606	5,184	5,208	6,702	5,920	6,529	3,664	5,522	2,931
99	4,762	4,785	6,158	5,438	5,998	3,324	5,074	2,659	5,358	5,383	6,926	6,118	6,747	3,738	5,707	2,990

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

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

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

THE MANHATTAN LIFE INSURANCE COMPANY
Annual Standard Premium Rates
FOR USE IN MISSOURI ZIP CODES
630, 631, 633, 640, 641

Issue	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	2,537	2,547	3,275	2,892	3,189	2,577	2,696	2,062	2,855	2,866	3,683	3,252	3,588	2,899	3,033	2,320
65	1,973	1,975	2,530	2,231	2,464	1,988	2,077	1,590	2,220	2,222	2,845	2,510	2,773	2,239	2,336	1,792
66	1,973	1,975	2,530	2,231	2,464	1,988	2,077	1,590	2,220	2,222	2,845	2,510	2,773	2,239	2,336	1,792
67	1,973	1,975	2,530	2,231	2,464	1,988	2,077	1,590	2,220	2,222	2,845	2,510	2,773	2,239	2,336	1,792
68	2,038	2,038	2,614	2,305	2,546	2,115	2,146	1,692	2,291	2,292	2,941	2,594	2,865	2,376	2,415	1,901
69	2,099	2,102	2,699	2,381	2,629	2,184	2,220	1,747	2,361	2,364	3,035	2,678	2,957	2,456	2,496	1,965
70	2,159	2,165	2,781	2,456	2,709	2,249	2,289	1,800	2,427	2,436	3,130	2,761	3,049	2,531	2,575	2,025
71	2,215	2,224	2,862	2,528	2,789	2,292	2,356	1,833	2,492	2,504	3,220	2,843	3,136	2,579	2,651	2,063
72	2,275	2,284	2,941	2,597	2,864	2,354	2,422	1,884	2,556	2,569	3,306	2,920	3,221	2,647	2,724	2,118
73	2,368	2,379	3,064	2,705	2,984	2,474	2,523	1,979	2,663	2,677	3,444	3,042	3,356	2,782	2,839	2,225
74	2,468	2,481	3,191	2,818	3,108	2,579	2,630	2,063	2,778	2,790	3,589	3,171	3,496	2,901	2,958	2,321
75	2,571	2,584	3,326	2,938	3,240	2,690	2,742	2,152	2,893	2,908	3,741	3,305	3,644	3,028	3,083	2,422
76	2,644	2,657	3,418	3,020	3,329	2,736	2,816	2,188	2,975	2,988	3,844	3,396	3,746	3,077	3,168	2,462
77	2,717	2,730	3,514	3,104	3,422	2,813	2,895	2,251	3,058	3,071	3,951	3,491	3,849	3,164	3,256	2,531
78	2,793	2,806	3,612	3,189	3,518	2,893	2,976	2,315	3,143	3,158	4,064	3,588	3,957	3,255	3,348	2,604
79	2,873	2,885	3,713	3,281	3,618	2,976	3,060	2,381	3,233	3,246	4,179	3,690	4,069	3,348	3,443	2,678
80	2,957	2,968	3,821	3,375	3,721	3,062	3,148	2,450	3,324	3,341	4,296	3,796	4,185	3,444	3,541	2,755
81	3,041	3,054	3,931	3,471	3,828	3,128	3,240	2,502	3,419	3,436	4,421	3,905	4,307	3,519	3,643	2,815
82	3,129	3,143	4,046	3,573	3,941	3,222	3,333	2,578	3,520	3,536	4,551	4,019	4,432	3,624	3,749	2,899
83	3,220	3,236	4,165	3,678	4,057	3,317	3,432	2,653	3,624	3,640	4,684	4,135	4,563	3,729	3,859	2,983
84	3,315	3,332	4,288	3,787	4,177	3,414	3,533	2,731	3,731	3,748	4,823	4,260	4,697	3,842	3,974	3,074
85	3,414	3,432	4,415	3,900	4,300	3,520	3,639	2,816	3,842	3,859	4,966	4,387	4,838	3,958	4,092	3,167
86	3,518	3,534	4,548	4,016	4,431	3,651	3,748	2,921	3,957	3,976	5,116	4,520	4,985	4,109	4,216	3,287
87	3,625	3,642	4,687	4,139	4,566	3,763	3,862	3,011	4,078	4,097	5,272	4,656	5,135	4,233	4,344	3,387
88	3,736	3,754	4,830	4,268	4,706	3,879	3,980	3,103	4,201	4,223	5,433	4,798	5,292	4,363	4,477	3,490
89	3,851	3,870	4,980	4,398	4,851	3,999	4,102	3,199	4,332	4,353	5,603	4,947	5,456	4,498	4,616	3,598
90	3,972	3,989	5,135	4,534	5,003	4,123	4,232	3,298	4,468	4,488	5,775	5,101	5,626	4,638	4,759	3,710
91	4,097	4,116	5,296	4,678	5,158	4,253	4,364	3,402	4,607	4,630	5,958	5,261	5,804	4,784	4,909	3,827
92	4,226	4,246	5,464	4,827	5,322	4,388	4,502	3,511	4,754	4,776	6,147	5,429	5,987	4,936	5,065	3,949
93	4,361	4,380	5,638	4,978	5,492	4,528	4,647	3,623	4,906	4,929	6,342	5,602	6,178	5,093	5,226	4,074
94	4,501	4,522	5,820	5,139	5,668	4,674	4,796	3,739	5,063	5,088	6,546	5,782	6,377	5,258	5,395	4,207
95	4,648	4,670	6,009	5,307	5,852	4,827	4,952	3,862	5,228	5,253	6,759	5,970	6,585	5,428	5,569	4,342
96	4,800	4,823	6,207	5,481	6,044	4,983	5,114	3,986	5,399	5,425	6,981	6,165	6,800	5,605	5,752	4,484
97	4,958	4,982	6,411	5,660	6,245	5,149	5,282	4,119	5,578	5,603	7,211	6,369	7,024	5,790	5,942	4,632
98	5,122	5,147	6,623	5,850	6,452	5,318	5,457	4,254	5,763	5,789	7,450	6,580	7,258	5,983	6,139	4,786
99	5,293	5,319	6,845	6,046	6,668	5,496	5,641	4,396	5,955	5,983	7,699	6,801	7,500	6,182	6,345	4,946

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

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

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

THE MANHATTAN LIFE INSURANCE COMPANY
Annual Preferred Premium Rates
FOR USE IN MISSOURI ZIP CODES ALL EXCEPT
630, 631, 633, 640, 641

Issue	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	1,985	1,993	2,561	2,262	2,495	2,017	2,109	1,614	2,232	2,242	2,882	2,544	2,807	2,269	2,372	1,815
65	1,544	1,545	1,980	1,745	1,928	1,556	1,624	1,245	1,736	1,738	2,226	1,963	2,169	1,751	1,827	1,401
66	1,544	1,545	1,980	1,745	1,928	1,556	1,624	1,245	1,736	1,738	2,226	1,963	2,169	1,751	1,827	1,401
67	1,544	1,545	1,980	1,745	1,928	1,556	1,624	1,245	1,736	1,738	2,226	1,963	2,169	1,751	1,827	1,401
68	1,594	1,595	2,045	1,803	1,991	1,601	1,679	1,281	1,792	1,793	2,300	2,029	2,241	1,800	1,889	1,440
69	1,643	1,644	2,111	1,863	2,057	1,647	1,736	1,318	1,847	1,850	2,375	2,095	2,313	1,852	1,952	1,482
70	1,688	1,693	2,176	1,921	2,120	1,692	1,790	1,354	1,898	1,905	2,449	2,160	2,385	1,904	2,014	1,523
71	1,733	1,740	2,240	1,977	2,181	1,722	1,843	1,378	1,949	1,958	2,519	2,223	2,454	1,938	2,074	1,550
72	1,779	1,787	2,300	2,031	2,241	1,752	1,895	1,402	2,000	2,010	2,586	2,284	2,520	1,971	2,131	1,577
73	1,853	1,861	2,396	2,116	2,334	1,797	1,974	1,438	2,084	2,094	2,695	2,380	2,625	2,022	2,221	1,618
74	1,931	1,940	2,497	2,204	2,431	1,845	2,057	1,476	2,173	2,182	2,808	2,480	2,735	2,076	2,314	1,661
75	2,012	2,022	2,603	2,298	2,535	1,896	2,145	1,517	2,264	2,275	2,927	2,585	2,852	2,133	2,412	1,706
76	2,069	2,077	2,674	2,361	2,605	1,927	2,203	1,542	2,327	2,337	3,008	2,657	2,930	2,169	2,478	1,735
77	2,125	2,136	2,748	2,427	2,677	1,960	2,265	1,568	2,392	2,402	3,091	2,731	3,011	2,205	2,547	1,764
78	2,186	2,196	2,826	2,495	2,752	1,994	2,328	1,595	2,459	2,470	3,179	2,807	3,096	2,243	2,619	1,794
79	2,247	2,258	2,905	2,566	2,830	2,029	2,394	1,623	2,528	2,540	3,269	2,887	3,183	2,283	2,693	1,826
80	2,312	2,322	2,988	2,640	2,911	2,066	2,462	1,653	2,600	2,613	3,362	2,969	3,274	2,324	2,770	1,859
81	2,379	2,389	3,075	2,716	2,995	2,089	2,533	1,671	2,675	2,688	3,459	3,055	3,369	2,350	2,850	1,880
82	2,448	2,459	3,164	2,795	3,083	2,113	2,607	1,690	2,753	2,766	3,560	3,144	3,467	2,377	2,933	1,902
83	2,519	2,532	3,257	2,877	3,173	2,138	2,684	1,710	2,834	2,847	3,664	3,236	3,570	2,404	3,019	1,923
84	2,594	2,606	3,354	2,963	3,267	2,163	2,764	1,730	2,918	2,932	3,773	3,332	3,674	2,433	3,109	1,946
85	2,672	2,684	3,453	3,051	3,364	2,190	2,846	1,752	3,006	3,019	3,885	3,431	3,785	2,463	3,201	1,970
86	2,752	2,765	3,559	3,143	3,466	2,234	2,932	1,787	3,095	3,110	4,002	3,535	3,899	2,512	3,298	2,010
87	2,836	2,849	3,666	3,238	3,572	2,279	3,021	1,823	3,190	3,205	4,124	3,642	4,017	2,563	3,398	2,050
88	2,922	2,937	3,779	3,337	3,681	2,324	3,113	1,859	3,287	3,303	4,250	3,754	4,140	2,614	3,502	2,091
89	3,013	3,027	3,895	3,440	3,794	2,371	3,209	1,897	3,389	3,405	4,382	3,870	4,268	2,666	3,611	2,133
90	3,108	3,121	4,017	3,548	3,913	2,418	3,310	1,934	3,495	3,511	4,518	3,991	4,401	2,720	3,723	2,176
91	3,204	3,220	4,142	3,659	4,036	2,466	3,414	1,973	3,604	3,622	4,660	4,116	4,540	2,774	3,840	2,219
92	3,306	3,322	4,274	3,775	4,163	2,516	3,522	2,013	3,719	3,736	4,808	4,247	4,683	2,830	3,962	2,264
93	3,412	3,427	4,410	3,895	4,297	2,566	3,635	2,053	3,838	3,856	4,961	4,382	4,833	2,886	4,088	2,309
94	3,521	3,538	4,553	4,020	4,434	2,617	3,752	2,094	3,961	3,980	5,121	4,523	4,988	2,944	4,220	2,355
95	3,636	3,653	4,700	4,152	4,579	2,670	3,874	2,136	4,090	4,109	5,288	4,669	5,151	3,003	4,357	2,402
96	3,755	3,773	4,855	4,287	4,728	2,723	4,000	2,178	4,223	4,243	5,461	4,822	5,319	3,063	4,500	2,450
97	3,878	3,897	5,015	4,429	4,885	2,778	4,132	2,222	4,363	4,383	5,640	4,982	5,494	3,124	4,648	2,499
98	4,007	4,026	5,181	4,576	5,046	2,833	4,269	2,266	4,508	4,529	5,828	5,148	5,677	3,186	4,802	2,549
99	4,141	4,161	5,355	4,729	5,216	2,890	4,412	2,312	4,659	4,681	6,023	5,320	5,867	3,250	4,963	2,600

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

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

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

THE MANHATTAN LIFE INSURANCE COMPANY
Annual Standard Premium Rates
FOR USE IN MISSOURI ZIP CODES ALL EXCEPT
630, 631, 633, 640, 641

Issue	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	2,206	2,215	2,848	2,515	2,773	2,241	2,344	1,793	2,483	2,492	3,203	2,828	3,120	2,521	2,637	2,017
65	1,716	1,717	2,200	1,940	2,143	1,729	1,806	1,383	1,930	1,932	2,474	2,183	2,411	1,947	2,031	1,558
66	1,716	1,717	2,200	1,940	2,143	1,729	1,806	1,383	1,930	1,932	2,474	2,183	2,411	1,947	2,031	1,558
67	1,716	1,717	2,200	1,940	2,143	1,729	1,806	1,383	1,930	1,932	2,474	2,183	2,411	1,947	2,031	1,558
68	1,772	1,772	2,273	2,004	2,214	1,839	1,866	1,471	1,992	1,993	2,557	2,256	2,491	2,066	2,100	1,653
69	1,825	1,828	2,347	2,070	2,286	1,899	1,930	1,519	2,053	2,056	2,639	2,329	2,571	2,136	2,170	1,709
70	1,877	1,883	2,418	2,136	2,356	1,956	1,990	1,565	2,110	2,118	2,722	2,401	2,651	2,201	2,239	1,761
71	1,926	1,934	2,489	2,198	2,425	1,993	2,049	1,594	2,167	2,177	2,800	2,472	2,727	2,243	2,305	1,794
72	1,978	1,986	2,557	2,258	2,490	2,047	2,106	1,638	2,223	2,234	2,875	2,539	2,801	2,302	2,369	1,842
73	2,059	2,069	2,664	2,352	2,595	2,151	2,194	1,721	2,316	2,328	2,995	2,645	2,918	2,419	2,469	1,935
74	2,146	2,157	2,775	2,450	2,703	2,243	2,287	1,794	2,416	2,426	3,121	2,757	3,040	2,523	2,572	2,018
75	2,236	2,247	2,892	2,555	2,817	2,339	2,384	1,871	2,516	2,529	3,253	2,874	3,169	2,633	2,681	2,106
76	2,299	2,310	2,972	2,626	2,895	2,379	2,449	1,903	2,587	2,598	3,343	2,953	3,257	2,676	2,755	2,141
77	2,363	2,374	3,056	2,699	2,976	2,446	2,517	1,957	2,659	2,670	3,436	3,036	3,347	2,751	2,831	2,201
78	2,429	2,440	3,141	2,773	3,059	2,516	2,588	2,013	2,733	2,746	3,534	3,120	3,441	2,830	2,911	2,264
79	2,498	2,509	3,229	2,853	3,146	2,588	2,661	2,070	2,811	2,823	3,634	3,209	3,538	2,911	2,994	2,329
80	2,571	2,581	3,323	2,935	3,236	2,663	2,737	2,130	2,890	2,905	3,736	3,301	3,639	2,995	3,079	2,396
81	2,644	2,656	3,418	3,018	3,329	2,720	2,817	2,176	2,973	2,988	3,844	3,396	3,745	3,060	3,168	2,448
82	2,721	2,733	3,518	3,107	3,427	2,802	2,898	2,242	3,061	3,075	3,957	3,495	3,854	3,151	3,260	2,521
83	2,800	2,814	3,622	3,198	3,528	2,884	2,984	2,307	3,151	3,165	4,073	3,596	3,968	3,243	3,356	2,594
84	2,883	2,897	3,729	3,293	3,632	2,969	3,072	2,375	3,244	3,259	4,194	3,704	4,084	3,341	3,456	2,673
85	2,969	2,984	3,839	3,391	3,739	3,061	3,164	2,449	3,341	3,356	4,318	3,815	4,207	3,442	3,558	2,754
86	3,059	3,073	3,955	3,492	3,853	3,175	3,259	2,540	3,441	3,457	4,449	3,930	4,335	3,573	3,666	2,858
87	3,152	3,167	4,076	3,599	3,970	3,272	3,358	2,618	3,546	3,563	4,584	4,049	4,465	3,681	3,777	2,945
88	3,249	3,264	4,200	3,711	4,092	3,373	3,461	2,698	3,653	3,672	4,724	4,172	4,602	3,794	3,893	3,035
89	3,349	3,365	4,330	3,824	4,218	3,477	3,567	2,782	3,767	3,785	4,872	4,302	4,744	3,911	4,014	3,129
90	3,454	3,469	4,465	3,943	4,350	3,585	3,680	2,868	3,885	3,903	5,022	4,436	4,892	4,033	4,138	3,226
91	3,563	3,579	4,605	4,068	4,485	3,698	3,795	2,958	4,006	4,026	5,181	4,575	5,047	4,160	4,269	3,328
92	3,675	3,692	4,751	4,197	4,628	3,816	3,915	3,053	4,134	4,153	5,345	4,721	5,206	4,292	4,404	3,434
93	3,792	3,809	4,903	4,329	4,776	3,937	4,041	3,150	4,266	4,286	5,515	4,871	5,372	4,429	4,544	3,543
94	3,914	3,932	5,061	4,469	4,929	4,064	4,170	3,251	4,403	4,424	5,692	5,028	5,545	4,572	4,691	3,658
95	4,042	4,061	5,225	4,615	5,089	4,197	4,306	3,358	4,546	4,568	5,877	5,191	5,726	4,720	4,843	3,776
96	4,174	4,194	5,397	4,766	5,256	4,333	4,447	3,466	4,695	4,717	6,070	5,361	5,913	4,874	5,002	3,899
97	4,311	4,332	5,575	4,922	5,430	4,477	4,593	3,582	4,850	4,872	6,270	5,538	6,108	5,035	5,167	4,028
98	4,454	4,476	5,759	5,087	5,610	4,624	4,745	3,699	5,011	5,034	6,478	5,722	6,311	5,203	5,338	4,162
99	4,603	4,625	5,952	5,257	5,798	4,779	4,905	3,823	5,178	5,203	6,695	5,914	6,522	5,376	5,517	4,301

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

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

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

PREMIUM INFORMATION

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 issue age, underwriting class, and state of residence.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

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 $1316	$0	$1316 (Part A deductible)
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	$0	Up to $164.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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	All but $1316	$1316 (Part A deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	$0	Up to $164.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE 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*	$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 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 $1316	$1316 (Part A deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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	$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 $1316	$1316 (Part A deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE 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	All but $1316	$1316 (Part A deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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*	$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	100%	$0
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

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	$183 (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 $1316	$1316 (Part A deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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*	$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	100%	0%
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 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 $1316	$658 (50% Part A deductible)	$658 (50% Part A deductible)
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE 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*	$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 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 $1316	$1316 (Part A deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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*	$0	$0	$183 (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 $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

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.