ManhattanLife Insurance and Annuity Company
Outline of Medicare Supplement Coverage-Cover Page
Benefit Plans A, F, G, AND N

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020.

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A." Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F. ManhattanLife Insurance and Annuity Company offers four of the twelve plans available, Plans A, F, G, and N.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants									Medicare first eligible before 2020 only		
	A	B	D	G	G[1]	K	L	M	N	C	F	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Medicare Part B coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓ Copays apply[3]	✓	✓	
Blood (first three pints)	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Part A hospice care coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Skilled nursing facility coinsurance			✓	✓		50%	75%	✓	✓	✓	✓	
Medicare Part A deductible		✓	✓	✓		50%	75%	50%	✓	✓	✓	
Medicare Part B deductible										✓	✓	
Medicare Part B excess charges				✓							✓	
Foreign travel emergency (up to plan limits)			✓	✓				✓	✓	✓	✓	
Out-of-pocket limit in 2024[2]						$7,060[2]	$3,530[2]					

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,800 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

MANHATTANLIFE INSURANCE AND ANNUITY COMPANY
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN TEXAS ZIP CODES
770-773, 775

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	8,351	N/A	N/A	N/A	9,604	N/A	N/A	N/A
65	1,823	2,219	1,823	1,256	2,097	2,553	2,097	1,444
66	1,823	2,219	1,823	1,256	2,097	2,553	2,097	1,444
67	1,823	2,219	1,823	1,256	2,097	2,553	2,097	1,444
68	1,826	2,262	1,828	1,290	2,101	2,598	2,104	1,483
69	1,888	2,336	1,888	1,329	2,170	2,685	2,171	1,527
70	1,949	2,411	1,953	1,369	2,244	2,773	2,244	1,574
71	2,016	2,489	2,017	1,428	2,318	2,863	2,320	1,639
72	2,085	2,566	2,087	1,484	2,398	2,951	2,400	1,707
73	2,155	2,642	2,157	1,541	2,478	3,040	2,480	1,773
74	2,236	2,746	2,237	1,607	2,569	3,159	2,573	1,847
75	2,327	2,867	2,330	1,680	2,675	3,297	2,679	1,933
76	2,412	2,981	2,415	1,743	2,775	3,428	2,778	2,006
77	2,512	3,101	2,513	1,807	2,887	3,566	2,890	2,078
78	2,621	3,227	2,623	1,872	3,014	3,712	3,016	2,151
79	2,742	3,365	2,744	1,938	3,154	3,870	3,156	2,227
80	2,876	3,511	2,880	2,014	3,309	4,038	3,312	2,316
81	3,023	3,663	3,026	2,122	3,478	4,212	3,481	2,440
82	3,184	3,826	3,187	2,239	3,661	4,399	3,666	2,576
83	3,357	3,999	3,360	2,366	3,861	4,599	3,866	2,722
84	3,548	4,181	3,550	2,503	4,079	4,809	4,082	2,880
85	3,752	4,376	3,756	2,656	4,315	5,032	4,320	3,053
86	3,951	4,562	3,954	2,803	4,542	5,248	4,547	3,223
87	4,159	4,761	4,161	2,956	4,781	5,476	4,788	3,401
88	4,366	4,973	4,372	3,114	5,023	5,719	5,028	3,582
89	4,578	5,198	4,584	3,273	5,265	5,978	5,271	3,764
90	4,789	5,413	4,794	3,430	5,507	6,225	5,513	3,945
91	4,987	5,611	4,993	3,581	5,736	6,454	5,741	4,117
92	5,184	5,817	5,188	3,727	5,961	6,691	5,966	4,287
93	5,375	6,006	5,381	3,873	6,183	6,907	6,188	4,454
94	5,564	6,194	5,568	4,015	6,400	7,124	6,404	4,619
95	5,748	6,382	5,754	4,155	6,611	7,340	6,616	4,780
96	5,875	6,517	5,880	4,247	6,755	7,493	6,763	4,884
97	5,991	6,647	5,997	4,333	6,891	7,644	6,897	4,983
98	6,107	6,774	6,111	4,414	7,022	7,790	7,029	5,077
99	6,216	6,896	6,221	4,494	7,149	7,928	7,155	5,168

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

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

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

MANHATTANLIFE INSURANCE AND ANNUITY COMPANY
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN TEXAS ZIP CODES
770-773, 775

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	9,604	N/A	N/A	N/A	11,044	N/A	N/A	N/A
65	2,097	2,553	2,097	1,444	2,411	2,934	2,412	1,661
66	2,097	2,553	2,097	1,444	2,411	2,934	2,412	1,661
67	2,097	2,553	2,097	1,444	2,411	2,934	2,412	1,661
68	2,101	2,598	2,104	1,483	2,417	2,988	2,419	1,704
69	2,170	2,685	2,171	1,527	2,496	3,089	2,499	1,755
70	2,244	2,773	2,244	1,574	2,580	3,189	2,581	1,811
71	2,318	2,863	2,320	1,639	2,665	3,291	2,669	1,887
72	2,398	2,951	2,400	1,707	2,758	3,394	2,760	1,962
73	2,478	3,040	2,480	1,773	2,849	3,495	2,852	2,039
74	2,569	3,159	2,573	1,847	2,955	3,634	2,957	2,125
75	2,675	3,297	2,679	1,933	3,078	3,793	3,081	2,223
76	2,775	3,428	2,778	2,006	3,189	3,942	3,194	2,306
77	2,887	3,566	2,890	2,078	3,322	4,101	3,324	2,389
78	3,014	3,712	3,016	2,151	3,467	4,269	3,469	2,474
79	3,154	3,870	3,156	2,227	3,628	4,451	3,630	2,561
80	3,309	4,038	3,312	2,316	3,804	4,643	3,808	2,662
81	3,478	4,212	3,481	2,440	4,000	4,846	4,002	2,807
82	3,661	4,399	3,666	2,576	4,212	5,060	4,215	2,961
83	3,861	4,599	3,866	2,722	4,441	5,288	4,444	3,129
84	4,079	4,809	4,082	2,880	4,692	5,530	4,695	3,312
85	4,315	5,032	4,320	3,053	4,962	5,788	4,967	3,512
86	4,542	5,248	4,547	3,223	5,224	6,034	5,230	3,705
87	4,781	5,476	4,788	3,401	5,499	6,297	5,505	3,911
88	5,023	5,719	5,028	3,582	5,776	6,577	5,783	4,118
89	5,265	5,978	5,271	3,764	6,056	6,875	6,061	4,329
90	5,507	6,225	5,513	3,945	6,334	7,159	6,341	4,538
91	5,736	6,454	5,741	4,117	6,597	7,421	6,603	4,735
92	5,961	6,691	5,966	4,287	6,855	7,692	6,861	4,929
93	6,183	6,907	6,188	4,454	7,110	7,942	7,117	5,124
94	6,400	7,124	6,404	4,619	7,359	8,192	7,367	5,311
95	6,611	7,340	6,616	4,780	7,602	8,440	7,609	5,496
96	6,755	7,493	6,763	4,884	7,771	8,617	7,776	5,617
97	6,891	7,644	6,897	4,983	7,925	8,790	7,932	5,730
98	7,022	7,790	7,029	5,077	8,075	8,958	8,084	5,838
99	7,149	7,928	7,155	5,168	8,222	9,120	8,229	5,943

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

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

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

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

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	7,500	N/A	N/A	N/A	8,626	N/A	N/A	N/A
65	1,637	1,993	1,637	1,128	1,884	2,293	1,884	1,297
66	1,637	1,993	1,637	1,128	1,884	2,293	1,884	1,297
67	1,637	1,993	1,637	1,128	1,884	2,293	1,884	1,297
68	1,640	2,031	1,642	1,158	1,887	2,334	1,890	1,332
69	1,696	2,098	1,696	1,194	1,949	2,411	1,950	1,372
70	1,751	2,165	1,754	1,230	2,016	2,491	2,016	1,413
71	1,811	2,236	1,812	1,282	2,082	2,571	2,084	1,472
72	1,873	2,305	1,874	1,333	2,153	2,650	2,155	1,534
73	1,935	2,373	1,937	1,384	2,225	2,731	2,227	1,593
74	2,008	2,467	2,009	1,443	2,308	2,837	2,311	1,659
75	2,090	2,575	2,092	1,509	2,403	2,961	2,407	1,736
76	2,166	2,677	2,169	1,566	2,492	3,079	2,495	1,801
77	2,256	2,785	2,257	1,623	2,593	3,203	2,596	1,866
78	2,354	2,898	2,356	1,681	2,707	3,334	2,709	1,932
79	2,463	3,023	2,465	1,740	2,832	3,476	2,834	2,000
80	2,583	3,153	2,587	1,809	2,972	3,627	2,975	2,080
81	2,715	3,290	2,718	1,906	3,123	3,783	3,126	2,191
82	2,860	3,437	2,862	2,011	3,288	3,951	3,292	2,313
83	3,015	3,592	3,018	2,125	3,468	4,130	3,473	2,444
84	3,186	3,755	3,188	2,248	3,664	4,319	3,667	2,587
85	3,370	3,930	3,374	2,385	3,875	4,519	3,880	2,742
86	3,548	4,097	3,551	2,517	4,080	4,713	4,084	2,894
87	3,735	4,276	3,737	2,655	4,294	4,918	4,300	3,055
88	3,922	4,467	3,927	2,797	4,511	5,136	4,516	3,217
89	4,112	4,669	4,117	2,940	4,729	5,369	4,735	3,380
90	4,301	4,862	4,306	3,081	4,946	5,591	4,952	3,543
91	4,479	5,039	4,484	3,217	5,152	5,797	5,157	3,698
92	4,656	5,224	4,660	3,347	5,353	6,009	5,358	3,850
93	4,828	5,394	4,833	3,478	5,553	6,203	5,558	4,000
94	4,997	5,563	5,001	3,606	5,748	6,398	5,752	4,149
95	5,162	5,732	5,168	3,732	5,937	6,592	5,942	4,293
96	5,277	5,853	5,281	3,814	6,067	6,730	6,074	4,386
97	5,381	5,970	5,386	3,892	6,190	6,866	6,194	4,476
98	5,485	6,084	5,488	3,964	6,307	6,997	6,313	4,560
99	5,583	6,193	5,587	4,036	6,420	7,121	6,426	4,641

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

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

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

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

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	8,626	N/A	N/A	N/A	9,919	N/A	N/A	N/A
65	1,884	2,293	1,884	1,297	2,165	2,635	2,166	1,492
66	1,884	2,293	1,884	1,297	2,165	2,635	2,166	1,492
67	1,884	2,293	1,884	1,297	2,165	2,635	2,166	1,492
68	1,887	2,334	1,890	1,332	2,171	2,684	2,173	1,531
69	1,949	2,411	1,950	1,372	2,242	2,774	2,245	1,576
70	2,016	2,491	2,016	1,413	2,317	2,864	2,318	1,627
71	2,082	2,571	2,084	1,472	2,394	2,956	2,397	1,695
72	2,153	2,650	2,155	1,534	2,477	3,049	2,479	1,762
73	2,225	2,731	2,227	1,593	2,559	3,139	2,562	1,831
74	2,308	2,837	2,311	1,659	2,654	3,264	2,656	1,909
75	2,403	2,961	2,407	1,736	2,765	3,407	2,767	1,996
76	2,492	3,079	2,495	1,801	2,864	3,541	2,868	2,071
77	2,593	3,203	2,596	1,866	2,984	3,683	2,986	2,146
78	2,707	3,334	2,709	1,932	3,114	3,834	3,116	2,222
79	2,832	3,476	2,834	2,000	3,258	3,997	3,260	2,300
80	2,972	3,627	2,975	2,080	3,416	4,170	3,420	2,391
81	3,123	3,783	3,126	2,191	3,593	4,352	3,595	2,521
82	3,288	3,951	3,292	2,313	3,783	4,544	3,786	2,660
83	3,468	4,130	3,473	2,444	3,989	4,749	3,992	2,810
84	3,664	4,319	3,667	2,587	4,214	4,966	4,217	2,975
85	3,875	4,519	3,880	2,742	4,456	5,198	4,461	3,154
86	4,080	4,713	4,084	2,894	4,692	5,419	4,698	3,328
87	4,294	4,918	4,300	3,055	4,939	5,656	4,944	3,512
88	4,511	5,136	4,516	3,217	5,188	5,907	5,194	3,699
89	4,729	5,369	4,735	3,380	5,439	6,175	5,444	3,888
90	4,946	5,591	4,952	3,543	5,689	6,430	5,695	4,076
91	5,152	5,797	5,157	3,698	5,925	6,665	5,931	4,252
92	5,353	6,009	5,358	3,850	6,157	6,908	6,162	4,427
93	5,553	6,203	5,558	4,000	6,386	7,133	6,392	4,602
94	5,748	6,398	5,752	4,149	6,610	7,357	6,616	4,770
95	5,937	6,592	5,942	4,293	6,828	7,581	6,834	4,936
96	6,067	6,730	6,074	4,386	6,979	7,740	6,984	5,045
97	6,190	6,866	6,194	4,476	7,118	7,895	7,124	5,147
98	6,307	6,997	6,313	4,560	7,253	8,045	7,260	5,244
99	6,420	7,121	6,426	4,641	7,385	8,191	7,390	5,338

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

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

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

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

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	6,650	N/A	N/A	N/A	7,648	N/A	N/A	N/A
65	1,452	1,767	1,452	1,000	1,670	2,033	1,670	1,150
66	1,452	1,767	1,452	1,000	1,670	2,033	1,670	1,150
67	1,452	1,767	1,452	1,000	1,670	2,033	1,670	1,150
68	1,454	1,801	1,456	1,027	1,673	2,069	1,675	1,181
69	1,503	1,860	1,503	1,059	1,728	2,138	1,729	1,216
70	1,552	1,920	1,555	1,090	1,787	2,208	1,787	1,253
71	1,606	1,982	1,606	1,137	1,846	2,280	1,847	1,305
72	1,661	2,043	1,662	1,182	1,909	2,350	1,911	1,360
73	1,716	2,104	1,717	1,227	1,973	2,421	1,975	1,412
74	1,780	2,187	1,781	1,280	2,046	2,516	2,049	1,471
75	1,853	2,283	1,855	1,338	2,130	2,626	2,134	1,539
76	1,920	2,374	1,923	1,388	2,209	2,730	2,212	1,597
77	2,000	2,469	2,001	1,439	2,299	2,840	2,301	1,655
78	2,087	2,570	2,089	1,490	2,400	2,956	2,402	1,713
79	2,184	2,680	2,185	1,543	2,511	3,081	2,513	1,773
80	2,290	2,796	2,294	1,604	2,635	3,216	2,638	1,844
81	2,407	2,917	2,410	1,690	2,769	3,354	2,772	1,943
82	2,535	3,047	2,538	1,783	2,915	3,503	2,919	2,051
83	2,673	3,185	2,675	1,884	3,075	3,662	3,079	2,167
84	2,825	3,329	2,827	1,993	3,248	3,830	3,251	2,294
85	2,988	3,485	2,991	2,115	3,436	4,007	3,440	2,431
86	3,146	3,633	3,148	2,232	3,617	4,179	3,621	2,566
87	3,312	3,791	3,314	2,354	3,807	4,360	3,812	2,708
88	3,477	3,960	3,481	2,479	4,000	4,554	4,004	2,853
89	3,646	4,139	3,650	2,607	4,193	4,760	4,198	2,997
90	3,813	4,310	3,818	2,731	4,385	4,957	4,390	3,142
91	3,971	4,468	3,976	2,852	4,567	5,139	4,572	3,278
92	4,128	4,632	4,131	2,968	4,746	5,328	4,751	3,413
93	4,280	4,782	4,285	3,084	4,924	5,500	4,928	3,547
94	4,431	4,932	4,434	3,197	5,096	5,673	5,100	3,678
95	4,577	5,082	4,582	3,308	5,264	5,845	5,268	3,806
96	4,678	5,189	4,682	3,382	5,379	5,967	5,385	3,889
97	4,770	5,293	4,776	3,450	5,488	6,087	5,492	3,968
98	4,863	5,394	4,866	3,515	5,592	6,203	5,597	4,043
99	4,950	5,491	4,954	3,578	5,692	6,313	5,698	4,115

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

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

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

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

Attained	Female				Male			
Age	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	7,648	N/A	N/A	N/A	8,794	N/A	N/A	N/A
65	1,670	2,033	1,670	1,150	1,920	2,337	1,920	1,323
66	1,670	2,033	1,670	1,150	1,920	2,337	1,920	1,323
67	1,670	2,033	1,670	1,150	1,920	2,337	1,920	1,323
68	1,673	2,069	1,675	1,181	1,925	2,380	1,926	1,357
69	1,728	2,138	1,729	1,216	1,987	2,460	1,990	1,398
70	1,787	2,208	1,787	1,253	2,055	2,540	2,055	1,442
71	1,846	2,280	1,847	1,305	2,122	2,620	2,125	1,502
72	1,909	2,350	1,911	1,360	2,196	2,703	2,198	1,563
73	1,973	2,421	1,975	1,412	2,269	2,783	2,271	1,624
74	2,046	2,516	2,049	1,471	2,353	2,894	2,355	1,692
75	2,130	2,626	2,134	1,539	2,451	3,020	2,454	1,770
76	2,209	2,730	2,212	1,597	2,540	3,139	2,543	1,836
77	2,299	2,840	2,301	1,655	2,645	3,265	2,647	1,902
78	2,400	2,956	2,402	1,713	2,761	3,400	2,762	1,970
79	2,511	3,081	2,513	1,773	2,889	3,544	2,890	2,039
80	2,635	3,216	2,638	1,844	3,029	3,697	3,032	2,120
81	2,769	3,354	2,772	1,943	3,185	3,859	3,187	2,235
82	2,915	3,503	2,919	2,051	3,354	4,029	3,357	2,358
83	3,075	3,662	3,079	2,167	3,536	4,211	3,539	2,491
84	3,248	3,830	3,251	2,294	3,736	4,403	3,738	2,638
85	3,436	4,007	3,440	2,431	3,951	4,609	3,955	2,797
86	3,617	4,179	3,621	2,566	4,160	4,805	4,165	2,951
87	3,807	4,360	3,812	2,708	4,379	5,015	4,383	3,114
88	4,000	4,554	4,004	2,853	4,599	5,237	4,605	3,279
89	4,193	4,760	4,198	2,997	4,822	5,475	4,826	3,447
90	4,385	4,957	4,390	3,142	5,044	5,701	5,049	3,614
91	4,567	5,139	4,572	3,278	5,253	5,909	5,258	3,770
92	4,746	5,328	4,751	3,413	5,458	6,125	5,464	3,925
93	4,924	5,500	4,928	3,547	5,661	6,324	5,667	4,080
94	5,096	5,673	5,100	3,678	5,860	6,523	5,866	4,229
95	5,264	5,845	5,268	3,806	6,054	6,721	6,059	4,377
96	5,379	5,967	5,385	3,889	6,188	6,862	6,192	4,473
97	5,488	6,087	5,492	3,968	6,311	7,000	6,316	4,563
98	5,592	6,203	5,597	4,043	6,430	7,133	6,437	4,649
99	5,692	6,313	5,698	4,115	6,547	7,262	6,552	4,733

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

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

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

PREMIUM INFORMATION

ManhattanLife Insurance and Annuity Company may change your premium if a new table of rates is applicable to the policy, and if such rate increase is approved by the Texas Department of Insurance. 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 household discount for qualified household discount applicants, and will change on Your Policy Anniversary Date.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to our Medicare Supplement Administrative Office at P. O. Box 925568, Houston, Texas 77292-5568. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither ManhattanLife Insurance and Annuity Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

LIMITATIONS AND EXCLUSIONS

We will not pay benefits for:

(a) expense incurred while this Policy is not in force, except as provided in the Extension of Benefits section;

(b) We will not pay benefits for hospital or skilled nursing facility charges incurred while this policy is not in force.

(c) that portion of any expense incurred which is paid for by Medicare;

(d) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take home drugs and eye refractions;

(e) services for which a charge is not normally made in the absence of insurance; or

(f) loss or expense that is payable under any other Medicare Supplement Insurance Policy or certificate.

REFUND OF PREMIUMS

The Policy does contain a Pro-Rata Refund provision which provides for the refund of that part of any premium You have paid which covers the period after the death occurs.

The Policy does contain a Cancellation By Insured provision which provides for a pro-rata refund of any premium paid beyond the date of cancellation of the Policy.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Please refer to your policy for details.

PLAN A
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1632	$0	$1632 (Part A deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for 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 A

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

*Once you have been billed $240 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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $240 of Medicare Approved Amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care.	Medicare co-payment/ coinsurance	$0

*****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

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

*Once you have been billed $240 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 $240 of Medicare Approved Amounts*	$0	$240 (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 $240 of Medicare Approved amounts*	$0	$240 (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 $240 of Medicare Approved Amounts*	$0	$240 (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 $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care.	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

*Once you have been billed $240 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 $240 of Medicare Approved Amounts*	$0	$0	$240 (Unless Part B deductible has been met)
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 $240 of Medicare Approved Amounts*	$0	$0	$240 (Unless Part B deductible has been met)
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 $240 of Medicare Approved Amounts*	$0	$0	$240 (Unless Part B deductible has been met)
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 $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care.	Medicare co-payment/ coinsurance	$0

****NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

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

*Once you have been billed $240 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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $240 of Medicare Approved Amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $240 (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.