

ManhattanLife Assurance Company Application Packet

Thank you for your interest in the ManhattanLife Assurance Medicare Supplement plan!

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

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

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

Other Important Information

Download Medicare's [Choosing a Medigap Policy Guide](#) (.pdf)

Download [Policy Outline](#) (.pdf)

Download [Application](#) (.pdf)

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

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

**ManhattanLife Assurance Company of America
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 Assurance Company of America 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%	✓	✓	✓	✓	✓
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 2022 ²						\$6,620 ²	\$3,310 ²					

¹ Plans F and G also have a high deductible option, which require first paying a plan deductible of \$2,490 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 Assurance Company of America
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN TEXAS ZIP CODES
770-773, 775

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	6,657	N/A	N/A	N/A	7,656	N/A	N/A	N/A
65	1,480	1,808	1,494	1,173	1,702	2,079	1,718	1,348
66	1,480	1,808	1,494	1,173	1,702	2,079	1,718	1,348
67	1,480	1,808	1,494	1,173	1,702	2,079	1,718	1,348
68	1,483	1,841	1,498	1,204	1,705	2,117	1,723	1,385
69	1,533	1,903	1,547	1,241	1,761	2,187	1,779	1,427
70	1,582	1,963	1,599	1,279	1,821	2,259	1,838	1,470
71	1,636	2,027	1,652	1,333	1,881	2,332	1,901	1,531
72	1,692	2,090	1,710	1,386	1,946	2,403	1,966	1,594
73	1,749	2,152	1,767	1,439	2,011	2,476	2,031	1,656
74	1,814	2,238	1,832	1,500	2,085	2,574	2,107	1,725
75	1,889	2,336	1,908	1,569	2,172	2,686	2,195	1,806
76	1,958	2,428	1,977	1,628	2,252	2,792	2,274	1,873
77	2,039	2,526	2,058	1,687	2,344	2,905	2,367	1,940
78	2,128	2,629	2,149	1,747	2,446	3,024	2,471	2,009
79	2,226	2,741	2,249	1,809	2,560	3,153	2,586	2,079
80	2,335	2,860	2,359	1,880	2,686	3,289	2,713	2,162
81	2,454	2,984	2,479	1,981	2,823	3,431	2,851	2,278
82	2,584	3,117	2,610	2,090	2,972	3,583	3,002	2,404
83	2,725	3,257	2,753	2,210	3,134	3,745	3,167	2,541
84	2,879	3,406	2,908	2,338	3,310	3,917	3,344	2,689
85	3,046	3,565	3,077	2,480	3,502	4,099	3,538	2,850
86	3,207	3,716	3,239	2,617	3,687	4,275	3,725	3,009
87	3,375	3,878	3,408	2,760	3,882	4,460	3,921	3,175
88	3,545	4,051	3,581	2,907	4,077	4,659	4,119	3,345
89	3,716	4,235	3,754	3,056	4,274	4,870	4,318	3,514
90	3,887	4,410	3,927	3,203	4,470	5,071	4,517	3,684
91	4,048	4,571	4,090	3,344	4,656	5,257	4,702	3,844
92	4,208	4,738	4,250	3,481	4,838	5,450	4,887	4,002
93	4,363	4,892	4,407	3,616	5,019	5,626	5,070	4,159
94	4,517	5,046	4,562	3,750	5,195	5,803	5,247	4,312
95	4,666	5,199	4,713	3,879	5,365	5,979	5,419	4,463
96	4,768	5,308	4,817	3,966	5,483	6,104	5,539	4,561
97	4,863	5,415	4,913	4,046	5,593	6,226	5,649	4,653
98	4,957	5,518	5,006	4,121	5,699	6,345	5,757	4,740
99	5,046	5,617	5,095	4,196	5,803	6,458	5,861	4,825

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 Assurance Company of America
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN TEXAS ZIP CODES
770-773, 775**

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	7,656	N/A	N/A	N/A	8,804	N/A	N/A	N/A
65	1,702	2,079	1,718	1,348	1,957	2,391	1,975	1,551
66	1,702	2,079	1,718	1,348	1,957	2,391	1,975	1,551
67	1,702	2,079	1,718	1,348	1,957	2,391	1,975	1,551
68	1,705	2,117	1,723	1,385	1,961	2,434	1,982	1,592
69	1,761	2,187	1,779	1,427	2,025	2,516	2,047	1,639
70	1,821	2,259	1,838	1,470	2,094	2,597	2,115	1,691
71	1,881	2,332	1,901	1,531	2,164	2,681	2,186	1,761
72	1,946	2,403	1,966	1,594	2,239	2,765	2,262	1,832
73	2,011	2,476	2,031	1,656	2,312	2,847	2,336	1,904
74	2,085	2,574	2,107	1,725	2,399	2,960	2,422	1,984
75	2,172	2,686	2,195	1,806	2,499	3,090	2,524	2,076
76	2,252	2,792	2,274	1,873	2,589	3,212	2,616	2,152
77	2,344	2,905	2,367	1,940	2,696	3,340	2,723	2,231
78	2,446	3,024	2,471	2,009	2,813	3,478	2,841	2,310
79	2,560	3,153	2,586	2,079	2,944	3,626	2,973	2,391
80	2,686	3,289	2,713	2,162	3,088	3,782	3,119	2,486
81	2,823	3,431	2,851	2,278	3,246	3,947	3,279	2,620
82	2,972	3,583	3,002	2,404	3,418	4,121	3,453	2,765
83	3,134	3,745	3,167	2,541	3,604	4,307	3,641	2,921
84	3,310	3,917	3,344	2,689	3,808	4,505	3,846	3,093
85	3,502	4,099	3,538	2,850	4,027	4,714	4,068	3,279
86	3,687	4,275	3,725	3,009	4,240	4,915	4,284	3,460
87	3,882	4,460	3,921	3,175	4,464	5,130	4,509	3,651
88	4,077	4,659	4,119	3,345	4,688	5,358	4,737	3,845
89	4,274	4,870	4,318	3,514	4,915	5,600	4,965	4,041
90	4,470	5,071	4,517	3,684	5,142	5,832	5,194	4,238
91	4,656	5,257	4,702	3,844	5,355	6,045	5,409	4,420
92	4,838	5,450	4,887	4,002	5,564	6,266	5,620	4,603
93	5,019	5,626	5,070	4,159	5,772	6,470	5,830	4,783
94	5,195	5,803	5,247	4,312	5,973	6,673	6,034	4,959
95	5,365	5,979	5,419	4,463	6,171	6,875	6,233	5,132
96	5,483	6,104	5,539	4,561	6,307	7,020	6,370	5,244
97	5,593	6,226	5,649	4,653	6,432	7,160	6,497	5,350
98	5,699	6,345	5,757	4,740	6,555	7,296	6,621	5,452
99	5,803	6,458	5,861	4,825	6,673	7,428	6,740	5,549

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

Semi Annual
1/2

Quarterly
1/4

Monthly
1/12

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

**ManhattanLife Assurance Company of America
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN TEXAS ZIP CODES
750-753, 760, 761, 774, 776, 777, 782, 784, 793, 794**

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	5,979	N/A	N/A	N/A	6,876	N/A	N/A	N/A
65	1,329	1,624	1,342	1,053	1,529	1,867	1,543	1,211
66	1,329	1,624	1,342	1,053	1,529	1,867	1,543	1,211
67	1,329	1,624	1,342	1,053	1,529	1,867	1,543	1,211
68	1,332	1,654	1,345	1,082	1,532	1,901	1,547	1,244
69	1,376	1,709	1,389	1,115	1,582	1,964	1,598	1,281
70	1,421	1,763	1,437	1,148	1,635	2,029	1,651	1,320
71	1,470	1,821	1,484	1,197	1,690	2,094	1,707	1,375
72	1,520	1,877	1,536	1,245	1,748	2,158	1,765	1,432
73	1,570	1,933	1,587	1,292	1,806	2,224	1,825	1,487
74	1,630	2,010	1,645	1,347	1,873	2,312	1,892	1,549
75	1,697	2,098	1,714	1,409	1,951	2,412	1,971	1,622
76	1,759	2,181	1,776	1,462	2,022	2,507	2,043	1,682
77	1,831	2,269	1,849	1,515	2,105	2,609	2,126	1,742
78	1,911	2,361	1,930	1,569	2,197	2,716	2,219	1,804
79	1,999	2,462	2,020	1,625	2,299	2,831	2,322	1,867
80	2,097	2,569	2,118	1,689	2,412	2,954	2,437	1,942
81	2,204	2,680	2,226	1,779	2,536	3,082	2,561	2,046
82	2,321	2,799	2,344	1,877	2,669	3,218	2,697	2,159
83	2,447	2,926	2,473	1,985	2,815	3,364	2,844	2,282
84	2,586	3,059	2,612	2,100	2,973	3,518	3,003	2,415
85	2,735	3,202	2,764	2,227	3,146	3,681	3,178	2,560
86	2,880	3,338	2,909	2,350	3,312	3,839	3,346	2,702
87	3,031	3,483	3,061	2,479	3,486	4,006	3,522	2,852
88	3,184	3,638	3,217	2,611	3,662	4,185	3,700	3,004
89	3,338	3,803	3,372	2,745	3,838	4,374	3,878	3,156
90	3,491	3,961	3,527	2,877	4,015	4,554	4,057	3,309
91	3,636	4,105	3,673	3,003	4,182	4,722	4,223	3,452
92	3,779	4,255	3,817	3,126	4,346	4,895	4,389	3,595
93	3,919	4,394	3,959	3,248	4,508	5,053	4,553	3,735
94	4,057	4,532	4,097	3,368	4,666	5,212	4,712	3,873
95	4,190	4,670	4,233	3,484	4,819	5,370	4,867	4,008
96	4,283	4,768	4,326	3,562	4,925	5,482	4,975	4,096
97	4,368	4,864	4,413	3,634	5,024	5,592	5,074	4,179
98	4,452	4,956	4,496	3,702	5,119	5,699	5,171	4,257
99	4,532	5,045	4,576	3,768	5,212	5,801	5,264	4,334

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

Semi Annual 1/2	Quarterly 1/4	Monthly 1/12
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There is a one-time \$25.00 policy fee.
A discount factor of .93 is applied for household discount applicants

**ManhattanLife Assurance Company of America
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN TEXAS ZIP CODES
750-753, 760, 761, 774, 776, 777, 782, 784, 793, 794**

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	6,876	N/A	N/A	N/A	7,907	N/A	N/A	N/A
65	1,529	1,867	1,543	1,211	1,758	2,148	1,774	1,393
66	1,529	1,867	1,543	1,211	1,758	2,148	1,774	1,393
67	1,529	1,867	1,543	1,211	1,758	2,148	1,774	1,393
68	1,532	1,901	1,547	1,244	1,762	2,186	1,780	1,430
69	1,582	1,964	1,598	1,281	1,819	2,260	1,838	1,472
70	1,635	2,029	1,651	1,320	1,881	2,333	1,899	1,519
71	1,690	2,094	1,707	1,375	1,944	2,408	1,963	1,582
72	1,748	2,158	1,765	1,432	2,011	2,483	2,031	1,645
73	1,806	2,224	1,825	1,487	2,077	2,557	2,098	1,710
74	1,873	2,312	1,892	1,549	2,154	2,659	2,176	1,782
75	1,951	2,412	1,971	1,622	2,245	2,775	2,267	1,864
76	2,022	2,507	2,043	1,682	2,325	2,885	2,349	1,933
77	2,105	2,609	2,126	1,742	2,421	3,000	2,445	2,004
78	2,197	2,716	2,219	1,804	2,527	3,123	2,552	2,075
79	2,299	2,831	2,322	1,867	2,644	3,256	2,670	2,148
80	2,412	2,954	2,437	1,942	2,773	3,397	2,801	2,233
81	2,536	3,082	2,561	2,046	2,916	3,545	2,945	2,353
82	2,669	3,218	2,697	2,159	3,070	3,702	3,101	2,483
83	2,815	3,364	2,844	2,282	3,237	3,868	3,270	2,624
84	2,973	3,518	3,003	2,415	3,420	4,046	3,454	2,778
85	3,146	3,681	3,178	2,560	3,617	4,234	3,654	2,945
86	3,312	3,839	3,346	2,702	3,808	4,414	3,848	3,108
87	3,486	4,006	3,522	2,852	4,009	4,608	4,050	3,280
88	3,662	4,185	3,700	3,004	4,211	4,812	4,254	3,453
89	3,838	4,374	3,878	3,156	4,414	5,029	4,459	3,630
90	4,015	4,554	4,057	3,309	4,618	5,238	4,665	3,806
91	4,182	4,722	4,223	3,452	4,809	5,429	4,858	3,970
92	4,346	4,895	4,389	3,595	4,997	5,628	5,048	4,134
93	4,508	5,053	4,553	3,735	5,184	5,811	5,236	4,296
94	4,666	5,212	4,712	3,873	5,365	5,994	5,419	4,454
95	4,819	5,370	4,867	4,008	5,543	6,175	5,598	4,609
96	4,925	5,482	4,975	4,096	5,665	6,305	5,721	4,710
97	5,024	5,592	5,074	4,179	5,777	6,431	5,836	4,805
98	5,119	5,699	5,171	4,257	5,887	6,553	5,947	4,897
99	5,212	5,801	5,264	4,334	5,994	6,672	6,054	4,984

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

Semi Annual 1/2	Quarterly 1/4	Monthly 1/12
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There is a one-time \$25.00 policy fee.
A discount factor of .93 is applied for household discount applicants

**ManhattanLife Assurance Company of America
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
FOR USE IN TEXAS ZIP CODES ALL EXCEPT
750-753, 760, 761, 770-777, 782, 784, 793, 794**

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	5,301	N/A	N/A	N/A	6,097	N/A	N/A	N/A
65	1,178	1,440	1,189	934	1,355	1,656	1,368	1,073
66	1,178	1,440	1,189	934	1,355	1,656	1,368	1,073
67	1,178	1,440	1,189	934	1,355	1,656	1,368	1,073
68	1,181	1,466	1,193	959	1,358	1,686	1,372	1,103
69	1,220	1,515	1,232	988	1,403	1,742	1,416	1,136
70	1,260	1,563	1,274	1,018	1,450	1,799	1,464	1,170
71	1,303	1,614	1,316	1,061	1,498	1,857	1,514	1,219
72	1,348	1,664	1,361	1,103	1,550	1,914	1,565	1,269
73	1,392	1,714	1,407	1,146	1,601	1,972	1,618	1,318
74	1,445	1,782	1,459	1,195	1,661	2,049	1,678	1,373
75	1,504	1,860	1,520	1,250	1,729	2,139	1,748	1,438
76	1,559	1,933	1,575	1,296	1,793	2,223	1,811	1,491
77	1,624	2,012	1,639	1,343	1,866	2,313	1,885	1,545
78	1,694	2,093	1,711	1,391	1,948	2,408	1,968	1,600
79	1,772	2,183	1,791	1,441	2,038	2,510	2,059	1,656
80	1,859	2,277	1,878	1,497	2,139	2,619	2,160	1,722
81	1,954	2,376	1,974	1,577	2,248	2,732	2,270	1,814
82	2,058	2,482	2,079	1,664	2,367	2,853	2,391	1,914
83	2,170	2,594	2,192	1,760	2,496	2,982	2,522	2,024
84	2,293	2,712	2,316	1,862	2,636	3,119	2,663	2,141
85	2,425	2,839	2,450	1,975	2,789	3,264	2,817	2,270
86	2,553	2,959	2,579	2,084	2,936	3,404	2,966	2,396
87	2,688	3,088	2,714	2,198	3,091	3,552	3,123	2,528
88	2,823	3,226	2,852	2,315	3,247	3,710	3,280	2,663
89	2,959	3,372	2,989	2,434	3,403	3,878	3,438	2,798
90	3,095	3,511	3,127	2,551	3,560	4,038	3,597	2,933
91	3,223	3,640	3,257	2,663	3,707	4,186	3,744	3,061
92	3,351	3,773	3,384	2,772	3,853	4,340	3,892	3,187
93	3,474	3,896	3,510	2,879	3,996	4,480	4,037	3,312
94	3,597	4,018	3,633	2,986	4,137	4,621	4,178	3,434
95	3,715	4,140	3,753	3,089	4,272	4,761	4,315	3,554
96	3,797	4,227	3,836	3,158	4,366	4,861	4,411	3,632
97	3,873	4,312	3,912	3,222	4,454	4,958	4,499	3,705
98	3,947	4,394	3,986	3,282	4,538	5,053	4,585	3,775
99	4,018	4,473	4,057	3,341	4,621	5,143	4,667	3,842

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

Semi Annual 1/2	Quarterly 1/4	Monthly 1/12
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There is a one-time \$25.00 policy fee.

A discount factor of .93 is applied for household discount applicants

**ManhattanLife Assurance Company of America
ANNUAL STANDARD ATTAINED AGE PREMIUMS
FOR USE IN TEXAS ZIP CODES ALL EXCEPT
750-753, 760, 761, 770-777, 782, 784, 793, 794**

Attained Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	6,097	N/A	N/A	N/A	7,011	N/A	N/A	N/A
65	1,355	1,656	1,368	1,073	1,558	1,904	1,573	1,235
66	1,355	1,656	1,368	1,073	1,558	1,904	1,573	1,235
67	1,355	1,656	1,368	1,073	1,558	1,904	1,573	1,235
68	1,358	1,686	1,372	1,103	1,562	1,938	1,578	1,268
69	1,403	1,742	1,416	1,136	1,613	2,004	1,630	1,305
70	1,450	1,799	1,464	1,170	1,668	2,068	1,684	1,347
71	1,498	1,857	1,514	1,219	1,723	2,135	1,741	1,403
72	1,550	1,914	1,565	1,269	1,783	2,202	1,801	1,459
73	1,601	1,972	1,618	1,318	1,841	2,267	1,860	1,516
74	1,661	2,049	1,678	1,373	1,910	2,357	1,929	1,580
75	1,729	2,139	1,748	1,438	1,990	2,460	2,010	1,653
76	1,793	2,223	1,811	1,491	2,061	2,558	2,083	1,714
77	1,866	2,313	1,885	1,545	2,147	2,660	2,168	1,777
78	1,948	2,408	1,968	1,600	2,240	2,769	2,263	1,840
79	2,038	2,510	2,059	1,656	2,344	2,887	2,368	1,904
80	2,139	2,619	2,160	1,722	2,459	3,012	2,484	1,980
81	2,248	2,732	2,270	1,814	2,585	3,143	2,611	2,086
82	2,367	2,853	2,391	1,914	2,722	3,282	2,749	2,202
83	2,496	2,982	2,522	2,024	2,870	3,430	2,899	2,326
84	2,636	3,119	2,663	2,141	3,032	3,587	3,062	2,463
85	2,789	3,264	2,817	2,270	3,207	3,754	3,240	2,611
86	2,936	3,404	2,966	2,396	3,376	3,914	3,412	2,755
87	3,091	3,552	3,123	2,528	3,554	4,085	3,591	2,908
88	3,247	3,710	3,280	2,663	3,733	4,266	3,772	3,062
89	3,403	3,878	3,438	2,798	3,914	4,459	3,953	3,218
90	3,560	4,038	3,597	2,933	4,094	4,644	4,136	3,375
91	3,707	4,186	3,744	3,061	4,264	4,813	4,307	3,520
92	3,853	4,340	3,892	3,187	4,431	4,990	4,475	3,665
93	3,996	4,480	4,037	3,312	4,596	5,152	4,642	3,809
94	4,137	4,621	4,178	3,434	4,757	5,314	4,805	3,949
95	4,272	4,761	4,315	3,554	4,914	5,475	4,963	4,087
96	4,366	4,861	4,411	3,632	5,022	5,590	5,072	4,176
97	4,454	4,958	4,499	3,705	5,122	5,702	5,174	4,260
98	4,538	5,053	4,585	3,775	5,219	5,810	5,273	4,341
99	4,621	5,143	4,667	3,842	5,314	5,915	5,367	4,419

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 Assurance Company of America 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 Assurance Company of America.

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 Assurance Company of America 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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1556 All but \$389 a day All but \$778 a day \$0 \$0	\$0 \$389 a day \$778 a day 100% of Medicare eligible expenses \$0	\$1556 (Part A deductible) \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$194.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$194.50 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 \$233 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 \$233 of Medicare Approved Amounts*	\$0	\$0	\$233 (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 \$233 of Medicare Approved Amounts*	\$0	\$0	\$233 (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 \$233 of Medicare Approved Amounts*	\$0	\$0	\$233 (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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1556 All but \$389 a day All but \$778 a day \$0 \$0	\$1556 (Part A deductible) \$389 a day \$778 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$194.50 a day \$0	\$0 Up to \$194.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 \$233 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 \$233 of Medicare Approved Amounts*	\$0	\$233 (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 \$233 of Medicare Approved amounts*	\$0	\$233 (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 \$233 of Medicare Approved Amounts*	\$0	\$233 (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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1556 All but \$389 a day All but \$778 a day \$0 \$0	\$1556 (Part A deductible) \$389 a day \$778 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$194.50 a day \$0	\$0 Up to \$194.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 \$233 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 \$233 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$233 (Unless Part B deductible has been met) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	0%
BLOOD First 3 pints Next \$233 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$233 (Unless Part B deductible has been met) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$233 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$233 (Unless Part B deductible has been met) \$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges</p>	<p>\$0 \$0</p>	<p>\$0 80% to a lifetime maximum benefit of \$50,000.</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies: First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1556 All but \$389 a day All but \$778 a day \$0 \$0	\$1556 (Part A deductible) \$389 a day \$778 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$194.50 a day \$0	\$0 Up to \$194.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 \$233 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 \$233 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The co- payment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$233 (Part B deductible) Up to \$20 per office visit and up to \$50 per emergency room visit. The co-payment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$233 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$233 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PLAN N
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$233 of Medicare Approved Amounts*	\$0	\$0	\$233 (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.