

**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%	✓	✓	✓	✓	✓
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 2023 ²						\$6,940 ²	\$3,470 ²					

¹ Plans F and G also have a high deductible option, which require first paying a plan deductible of \$2,700 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 Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	7,456	N/A	N/A	N/A	8,575	N/A	N/A	N/A
65	1,628	1,988	1,628	1,197	1,873	2,287	1,873	1,375
66	1,628	1,988	1,628	1,197	1,873	2,287	1,873	1,375
67	1,628	1,988	1,628	1,197	1,873	2,287	1,873	1,375
68	1,631	2,026	1,633	1,228	1,876	2,328	1,878	1,413
69	1,686	2,093	1,686	1,266	1,938	2,406	1,939	1,455
70	1,741	2,160	1,743	1,305	2,003	2,485	2,003	1,499
71	1,800	2,230	1,801	1,360	2,069	2,565	2,071	1,562
72	1,862	2,299	1,863	1,414	2,141	2,644	2,143	1,626
73	1,923	2,367	1,926	1,468	2,212	2,724	2,214	1,689
74	1,996	2,461	1,997	1,530	2,294	2,831	2,297	1,759
75	2,078	2,569	2,080	1,601	2,389	2,955	2,392	1,841
76	2,154	2,671	2,156	1,660	2,478	3,072	2,480	1,911
77	2,243	2,779	2,244	1,720	2,578	3,196	2,580	1,979
78	2,340	2,891	2,343	1,782	2,691	3,326	2,694	2,049
79	2,448	3,015	2,451	1,846	2,816	3,468	2,818	2,121
80	2,568	3,146	2,571	1,918	2,955	3,618	2,957	2,205
81	2,699	3,282	2,702	2,021	3,105	3,775	3,108	2,323
82	2,843	3,429	2,846	2,132	3,269	3,942	3,272	2,453
83	2,997	3,583	3,000	2,254	3,447	4,120	3,452	2,592
84	3,168	3,747	3,170	2,385	3,642	4,309	3,645	2,743
85	3,350	3,921	3,353	2,529	3,852	4,509	3,857	2,907
86	3,527	4,088	3,531	2,669	4,055	4,702	4,060	3,069
87	3,713	4,266	3,715	2,816	4,269	4,906	4,275	3,239
88	3,899	4,456	3,903	2,966	4,485	5,125	4,490	3,412
89	4,088	4,658	4,092	3,118	4,701	5,357	4,707	3,585
90	4,276	4,850	4,280	3,267	4,917	5,578	4,923	3,757
91	4,453	5,027	4,458	3,411	5,121	5,783	5,126	3,920
92	4,629	5,212	4,632	3,550	5,322	5,995	5,327	4,082
93	4,800	5,382	4,804	3,688	5,521	6,188	5,525	4,242
94	4,968	5,550	4,972	3,824	5,714	6,383	5,719	4,399
95	5,132	5,719	5,138	3,957	5,902	6,577	5,908	4,552
96	5,246	5,840	5,250	4,045	6,032	6,714	6,038	4,652
97	5,349	5,956	5,355	4,127	6,153	6,849	6,158	4,746
98	5,453	6,070	5,456	4,203	6,269	6,980	6,276	4,835
99	5,550	6,179	5,554	4,280	6,383	7,104	6,388	4,922

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 Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	8,575	N/A	N/A	N/A	9,860	N/A	N/A	N/A
65	1,873	2,287	1,873	1,375	2,152	2,630	2,154	1,582
66	1,873	2,287	1,873	1,375	2,152	2,630	2,154	1,582
67	1,873	2,287	1,873	1,375	2,152	2,630	2,154	1,582
68	1,876	2,328	1,878	1,413	2,158	2,677	2,160	1,623
69	1,938	2,406	1,939	1,455	2,228	2,768	2,231	1,672
70	2,003	2,485	2,003	1,499	2,304	2,858	2,305	1,725
71	2,069	2,565	2,071	1,562	2,380	2,948	2,382	1,797
72	2,141	2,644	2,143	1,626	2,462	3,041	2,465	1,868
73	2,212	2,724	2,214	1,689	2,543	3,132	2,547	1,942
74	2,294	2,831	2,297	1,759	2,638	3,256	2,641	2,024
75	2,389	2,955	2,392	1,841	2,749	3,399	2,751	2,117
76	2,478	3,072	2,480	1,911	2,848	3,533	2,851	2,196
77	2,578	3,196	2,580	1,979	2,966	3,674	2,968	2,276
78	2,691	3,326	2,694	2,049	3,095	3,825	3,097	2,357
79	2,816	3,468	2,818	2,121	3,239	3,988	3,241	2,439
80	2,955	3,618	2,957	2,205	3,397	4,160	3,400	2,536
81	3,105	3,775	3,108	2,323	3,572	4,343	3,574	2,673
82	3,269	3,942	3,272	2,453	3,761	4,534	3,764	2,820
83	3,447	4,120	3,452	2,592	3,965	4,738	3,968	2,980
84	3,642	4,309	3,645	2,743	4,189	4,955	4,191	3,155
85	3,852	4,509	3,857	2,907	4,430	5,186	4,434	3,345
86	4,055	4,702	4,060	3,069	4,665	5,406	4,670	3,529
87	4,269	4,906	4,275	3,239	4,910	5,643	4,915	3,725
88	4,485	5,125	4,490	3,412	5,157	5,894	5,163	3,921
89	4,701	5,357	4,707	3,585	5,406	6,160	5,412	4,122
90	4,917	5,578	4,923	3,757	5,656	6,415	5,661	4,322
91	5,121	5,783	5,126	3,920	5,890	6,650	5,896	4,509
92	5,322	5,995	5,327	4,082	6,120	6,893	6,126	4,695
93	5,521	6,188	5,525	4,242	6,348	7,117	6,355	4,879
94	5,714	6,383	5,719	4,399	6,571	7,341	6,577	5,059
95	5,902	6,577	5,908	4,552	6,788	7,563	6,793	5,235
96	6,032	6,714	6,038	4,652	6,938	7,722	6,943	5,349
97	6,153	6,849	6,158	4,746	7,076	7,876	7,082	5,457
98	6,269	6,980	6,276	4,835	7,210	8,027	7,218	5,561
99	6,383	7,104	6,388	4,922	7,341	8,171	7,347	5,660

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 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 Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	6,697	N/A	N/A	N/A	7,702	N/A	N/A	N/A
65	1,462	1,786	1,462	1,075	1,682	2,054	1,682	1,235
66	1,462	1,786	1,462	1,075	1,682	2,054	1,682	1,235
67	1,462	1,786	1,462	1,075	1,682	2,054	1,682	1,235
68	1,465	1,820	1,467	1,103	1,685	2,091	1,687	1,269
69	1,514	1,880	1,514	1,137	1,740	2,161	1,741	1,307
70	1,564	1,940	1,566	1,172	1,799	2,232	1,799	1,346
71	1,617	2,003	1,618	1,221	1,859	2,304	1,860	1,403
72	1,672	2,065	1,673	1,270	1,923	2,375	1,924	1,461
73	1,728	2,126	1,730	1,318	1,987	2,446	1,989	1,517
74	1,793	2,211	1,794	1,374	2,060	2,542	2,063	1,580
75	1,866	2,308	1,868	1,438	2,146	2,654	2,149	1,654
76	1,934	2,399	1,936	1,491	2,225	2,759	2,227	1,716
77	2,015	2,496	2,016	1,545	2,315	2,870	2,317	1,777
78	2,102	2,597	2,104	1,601	2,417	2,988	2,419	1,840
79	2,199	2,708	2,201	1,658	2,529	3,115	2,531	1,905
80	2,307	2,826	2,310	1,723	2,654	3,250	2,656	1,981
81	2,424	2,948	2,427	1,815	2,789	3,390	2,792	2,086
82	2,553	3,080	2,556	1,915	2,936	3,541	2,939	2,203
83	2,692	3,218	2,695	2,024	3,096	3,701	3,100	2,328
84	2,845	3,365	2,847	2,142	3,271	3,870	3,274	2,464
85	3,009	3,522	3,012	2,272	3,460	4,050	3,464	2,611
86	3,168	3,671	3,171	2,397	3,642	4,223	3,646	2,757
87	3,335	3,832	3,337	2,529	3,834	4,407	3,839	2,909
88	3,502	4,002	3,506	2,664	4,028	4,603	4,032	3,064
89	3,671	4,184	3,675	2,800	4,222	4,811	4,227	3,219
90	3,840	4,356	3,844	2,934	4,416	5,010	4,421	3,375
91	3,999	4,515	4,004	3,063	4,600	5,194	4,604	3,521
92	4,157	4,681	4,160	3,188	4,780	5,384	4,784	3,667
93	4,311	4,834	4,315	3,313	4,959	5,558	4,963	3,810
94	4,462	4,985	4,466	3,435	5,132	5,733	5,136	3,951
95	4,609	5,136	4,614	3,554	5,301	5,907	5,306	4,089
96	4,711	5,245	4,715	3,633	5,417	6,030	5,423	4,178
97	4,804	5,350	4,809	3,706	5,526	6,152	5,531	4,262
98	4,898	5,451	4,900	3,775	5,631	6,269	5,637	4,343
99	4,985	5,549	4,989	3,844	5,733	6,381	5,738	4,420

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 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 Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	7,702	N/A	N/A	N/A	8,856	N/A	N/A	N/A
65	1,682	2,054	1,682	1,235	1,933	2,362	1,934	1,421
66	1,682	2,054	1,682	1,235	1,933	2,362	1,934	1,421
67	1,682	2,054	1,682	1,235	1,933	2,362	1,934	1,421
68	1,685	2,091	1,687	1,269	1,938	2,405	1,940	1,458
69	1,740	2,161	1,741	1,307	2,001	2,486	2,004	1,502
70	1,799	2,232	1,799	1,346	2,069	2,567	2,070	1,549
71	1,859	2,304	1,860	1,403	2,138	2,648	2,140	1,614
72	1,923	2,375	1,924	1,461	2,212	2,732	2,214	1,678
73	1,987	2,446	1,989	1,517	2,284	2,813	2,287	1,744
74	2,060	2,542	2,063	1,580	2,370	2,925	2,372	1,818
75	2,146	2,654	2,149	1,654	2,469	3,053	2,471	1,901
76	2,225	2,759	2,227	1,716	2,558	3,173	2,561	1,972
77	2,315	2,870	2,317	1,777	2,664	3,300	2,666	2,044
78	2,417	2,988	2,419	1,840	2,780	3,436	2,782	2,117
79	2,529	3,115	2,531	1,905	2,909	3,582	2,911	2,190
80	2,654	3,250	2,656	1,981	3,051	3,736	3,054	2,278
81	2,789	3,390	2,792	2,086	3,208	3,900	3,210	2,401
82	2,936	3,541	2,939	2,203	3,378	4,072	3,380	2,533
83	3,096	3,701	3,100	2,328	3,561	4,255	3,564	2,676
84	3,271	3,870	3,274	2,464	3,763	4,450	3,765	2,833
85	3,460	4,050	3,464	2,611	3,979	4,658	3,983	3,004
86	3,642	4,223	3,646	2,757	4,189	4,856	4,194	3,170
87	3,834	4,407	3,839	2,909	4,410	5,068	4,414	3,346
88	4,028	4,603	4,032	3,064	4,632	5,293	4,638	3,522
89	4,222	4,811	4,227	3,219	4,856	5,533	4,861	3,702
90	4,416	5,010	4,421	3,375	5,080	5,762	5,085	3,882
91	4,600	5,194	4,604	3,521	5,290	5,972	5,295	4,050
92	4,780	5,384	4,784	3,667	5,497	6,191	5,502	4,217
93	4,959	5,558	4,963	3,810	5,702	6,392	5,707	4,382
94	5,132	5,733	5,136	3,951	5,901	6,593	5,907	4,543
95	5,301	5,907	5,306	4,089	6,096	6,793	6,101	4,702
96	5,417	6,030	5,423	4,178	6,231	6,936	6,236	4,804
97	5,526	6,152	5,531	4,262	6,355	7,074	6,360	4,901
98	5,631	6,269	5,637	4,343	6,476	7,209	6,483	4,995
99	5,733	6,381	5,738	4,420	6,593	7,339	6,599	5,084

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 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 Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	5,937	N/A	N/A	N/A	6,828	N/A	N/A	N/A
65	1,296	1,583	1,296	953	1,491	1,821	1,491	1,095
66	1,296	1,583	1,296	953	1,491	1,821	1,491	1,095
67	1,296	1,583	1,296	953	1,491	1,821	1,491	1,095
68	1,299	1,613	1,300	978	1,494	1,854	1,496	1,125
69	1,342	1,667	1,342	1,008	1,543	1,916	1,544	1,158
70	1,386	1,720	1,388	1,039	1,595	1,979	1,595	1,194
71	1,434	1,776	1,434	1,083	1,648	2,043	1,649	1,244
72	1,483	1,831	1,484	1,126	1,705	2,105	1,706	1,295
73	1,532	1,885	1,533	1,169	1,761	2,169	1,763	1,345
74	1,589	1,960	1,590	1,219	1,827	2,254	1,829	1,401
75	1,655	2,046	1,656	1,275	1,902	2,353	1,905	1,466
76	1,715	2,127	1,717	1,322	1,973	2,446	1,975	1,521
77	1,786	2,213	1,787	1,370	2,053	2,545	2,055	1,576
78	1,864	2,302	1,865	1,419	2,143	2,649	2,145	1,631
79	1,950	2,401	1,951	1,470	2,242	2,761	2,244	1,689
80	2,045	2,505	2,048	1,527	2,353	2,881	2,355	1,756
81	2,149	2,614	2,152	1,609	2,473	3,006	2,475	1,850
82	2,264	2,731	2,266	1,698	2,603	3,139	2,606	1,953
83	2,387	2,853	2,389	1,795	2,745	3,281	2,749	2,064
84	2,522	2,983	2,524	1,899	2,900	3,431	2,903	2,184
85	2,668	3,123	2,670	2,014	3,068	3,591	3,071	2,315
86	2,809	3,255	2,811	2,125	3,229	3,744	3,233	2,444
87	2,957	3,397	2,958	2,242	3,400	3,907	3,404	2,579
88	3,105	3,548	3,108	2,362	3,572	4,081	3,575	2,717
89	3,255	3,709	3,259	2,483	3,744	4,266	3,748	2,854
90	3,405	3,862	3,408	2,602	3,916	4,442	3,920	2,992
91	3,546	4,003	3,550	2,716	4,078	4,605	4,082	3,122
92	3,686	4,150	3,689	2,827	4,238	4,774	4,242	3,251
93	3,822	4,285	3,825	2,937	4,396	4,928	4,400	3,378
94	3,956	4,420	3,959	3,045	4,550	5,083	4,554	3,503
95	4,087	4,554	4,091	3,151	4,700	5,237	4,704	3,625
96	4,177	4,650	4,180	3,221	4,803	5,347	4,808	3,704
97	4,260	4,743	4,264	3,286	4,899	5,454	4,904	3,779
98	4,342	4,833	4,345	3,347	4,992	5,558	4,997	3,850
99	4,420	4,920	4,423	3,408	5,083	5,657	5,087	3,919

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 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 Age	Female				Male			
	Plan A	Plan F	Plan G	Plan N	Plan A	Plan F	Plan G	Plan N
0-64	6,828	N/A	N/A	N/A	7,852	N/A	N/A	N/A
65	1,491	1,821	1,491	1,095	1,714	2,094	1,715	1,260
66	1,491	1,821	1,491	1,095	1,714	2,094	1,715	1,260
67	1,491	1,821	1,491	1,095	1,714	2,094	1,715	1,260
68	1,494	1,854	1,496	1,125	1,718	2,132	1,720	1,293
69	1,543	1,916	1,544	1,158	1,774	2,204	1,777	1,331
70	1,595	1,979	1,595	1,194	1,834	2,276	1,835	1,373
71	1,648	2,043	1,649	1,244	1,895	2,348	1,897	1,431
72	1,705	2,105	1,706	1,295	1,961	2,422	1,963	1,488
73	1,761	2,169	1,763	1,345	2,025	2,494	2,028	1,546
74	1,827	2,254	1,829	1,401	2,101	2,593	2,103	1,612
75	1,902	2,353	1,905	1,466	2,189	2,706	2,190	1,686
76	1,973	2,446	1,975	1,521	2,268	2,813	2,270	1,748
77	2,053	2,545	2,055	1,576	2,362	2,926	2,363	1,812
78	2,143	2,649	2,145	1,631	2,465	3,046	2,466	1,877
79	2,242	2,761	2,244	1,689	2,579	3,176	2,581	1,942
80	2,353	2,881	2,355	1,756	2,705	3,313	2,707	2,019
81	2,473	3,006	2,475	1,850	2,844	3,458	2,846	2,129
82	2,603	3,139	2,606	1,953	2,995	3,610	2,997	2,245
83	2,745	3,281	2,749	2,064	3,157	3,773	3,160	2,373
84	2,900	3,431	2,903	2,184	3,336	3,946	3,338	2,512
85	3,068	3,591	3,071	2,315	3,528	4,130	3,531	2,663
86	3,229	3,744	3,233	2,444	3,714	4,305	3,719	2,810
87	3,400	3,907	3,404	2,579	3,910	4,494	3,914	2,966
88	3,572	4,081	3,575	2,717	4,107	4,693	4,112	3,123
89	3,744	4,266	3,748	2,854	4,305	4,905	4,309	3,283
90	3,916	4,442	3,920	2,992	4,504	5,108	4,508	3,442
91	4,078	4,605	4,082	3,122	4,690	5,295	4,695	3,591
92	4,238	4,774	4,242	3,251	4,874	5,489	4,878	3,738
93	4,396	4,928	4,400	3,378	5,055	5,667	5,060	3,885
94	4,550	5,083	4,554	3,503	5,232	5,845	5,237	4,028
95	4,700	5,237	4,704	3,625	5,405	6,023	5,409	4,168
96	4,803	5,347	4,808	3,704	5,525	6,149	5,529	4,260
97	4,899	5,454	4,904	3,779	5,635	6,272	5,639	4,346
98	4,992	5,558	4,997	3,850	5,741	6,392	5,747	4,428
99	5,083	5,657	5,087	3,919	5,845	6,507	5,851	4,507

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 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 \$1600 All but \$400 a day All but \$800 a day \$0 \$0	\$0 \$400 a day \$800 a day 100% of Medicare eligible expenses \$0	\$1600 (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 \$200 a day \$0	\$0 \$0 \$0	\$0 Up to \$200 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 \$226 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 \$226 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$226 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$226 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$226 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$226 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% \$0 80%	 \$0 \$0 20%	 \$0 \$226 (Part B deductible) \$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 \$1600 All but \$400 a day All but \$800 a day \$0 \$0	\$1600 (Part A deductible) \$400 a day \$800 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 \$200 a day \$0	\$0 Up to \$200 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 \$226 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 \$226 of Medicare Approved Amounts*	\$0	\$226 (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 \$226 of Medicare Approved amounts*	\$0	\$226 (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 \$226 of Medicare Approved Amounts*	\$0	\$226 (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 \$1600 All but \$400 a day All but \$800 a day \$0 \$0	\$1600 (Part A deductible) \$400 a day \$800 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 \$200 a day \$0	\$0 Up to \$200 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 \$226 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 \$226 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$226 (Unless Part B deductible has been met) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	0%
BLOOD First 3 pints Next \$226 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$226 (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 \$226 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$226 (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</p>			
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 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 \$1600 All but \$400 a day All but \$800 a day \$0 \$0	\$1600 (Part A deductible) \$400 a day \$800 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 \$200 a day \$0	\$0 Up to \$200 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 \$226 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 \$226 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.	\$226 (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 \$226 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$226 (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 \$226 of Medicare Approved Amounts*	\$0	\$0	\$226 (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.