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

MEDICARE SUPPLEMENT INSURANCE

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

PREMIUM INFORMATION

The Manhattan Life Insurance Company may change your premium if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class on the date of change. Class is defined as attained age, underwriting class, state and zip code of residence.

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

RENEWABILITY

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

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

This policy may not fully cover all of your medical costs.

Neither The Manhattan Life Insurance Company nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

USUAL, CUSTOMARY, AND REASONABLE CHARGES (UCR)

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

THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL PREFERRED PREMIUM RATES
FOR USE IN WISCONSIN ZIP CODES
530-534

Attained Age	Base Plan		Base Plan Part B Copay		Part A Ded Rider		Part B Ded Rider		Part B Excess Rider		Additional Home Care Rider		Foreign Travel Rider	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-64	4,131	4,750	3,317	3,815	748	860	166	166	55	63	60	70	37	43
65	1,377	1,583	1,106	1,272	249	286	166	166	19	21	20	23	13	15
66	1,377	1,583	1,106	1,272	249	286	166	166	19	21	20	23	13	15
67	1,377	1,583	1,106	1,272	249	286	166	166	19	21	20	23	13	15
68	1,437	1,653	1,153	1,326	261	299	166	166	20	22	21	24	13	15
69	1,499	1,723	1,201	1,380	273	314	166	166	20	23	22	25	14	16
70	1,559	1,793	1,248	1,435	282	324	166	166	20	23	22	26	14	16
71	1,613	1,854	1,290	1,483	296	339	166	166	21	24	23	27	15	17
72	1,666	1,915	1,333	1,533	310	356	166	166	22	25	24	28	15	17
73	1,719	1,977	1,375	1,581	323	371	166	166	22	26	25	28	16	18
74	1,772	2,038	1,418	1,630	337	387	166	166	23	27	25	29	16	19
75	1,827	2,101	1,462	1,681	352	404	166	166	24	27	26	30	17	19
76	1,880	2,162	1,506	1,733	367	422	166	166	24	28	27	31	17	20
77	1,934	2,225	1,551	1,784	385	442	166	166	25	29	28	32	18	20
78	1,991	2,291	1,599	1,838	403	463	166	166	26	30	28	33	18	20
79	2,050	2,357	1,646	1,893	420	485	166	166	27	31	29	33	19	20
80	2,108	2,425	1,695	1,950	439	506	166	166	27	32	30	34	19	21
81	2,172	2,497	1,749	2,012	458	527	166	166	28	32	31	35	19	21
82	2,235	2,570	1,805	2,076	477	549	166	166	29	33	32	35	20	22
83	2,302	2,647	1,863	2,143	498	572	166	166	29	33	32	37	20	22
84	2,371	2,727	1,923	2,211	517	595	166	166	30	34	33	38	20	23
85	2,441	2,807	1,983	2,280	538	619	166	166	31	35	33	39	20	24
86	2,515	2,893	2,048	2,355	556	639	166	166	32	35	34	40	21	24
87	2,591	2,980	2,113	2,431	575	661	166	166	32	37	35	41	21	25
88	2,669	3,070	2,181	2,509	594	683	166	166	33	38	37	42	22	25
89	2,745	3,156	2,247	2,584	612	704	166	166	33	39	37	43	22	26
90	2,819	3,241	2,311	2,658	631	725	166	166	34	40	38	44	23	27
91	2,888	3,320	2,372	2,729	647	744	166	166	34	41	39	45	23	27
92	2,953	3,395	2,431	2,795	661	761	166	166	35	41	39	45	24	27
93	3,013	3,464	2,485	2,857	676	777	166	166	35	42	40	46	24	28
94	3,074	3,535	2,539	2,920	690	793	166	166	37	42	40	47	24	28
95	3,137	3,607	2,595	2,984	704	809	166	166	37	43	41	47	25	28
96	3,198	3,679	2,647	3,044	719	826	166	166	38	44	42	47	25	29
97	3,263	3,753	2,701	3,104	733	843	166	166	39	45	43	48	26	30
98	3,328	3,827	2,755	3,168	748	860	166	166	39	46	43	49	26	30
99	3,395	3,903	2,809	3,231	763	876	166	166	40	46	44	50	27	31

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

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

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

THE MANHATTAN LIFE INSURANCE COMPANY
ANNUAL STANDARD PREMIUM RATES
FOR USE IN WISCONSIN ZIP CODES
530-534

Attained Age	Base Plan		Base Plan Part B Copay		Part A Ded Rider		Part B Ded Rider		Part B Excess Rider		Additional Home Care		Foreign Travel Rider	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-64	4,750	5,463	3,815	4,387	860	989	166	166	63	73	70	79	43	48
65	1,583	1,821	1,272	1,462	286	330	166	166	21	24	23	26	15	17
66	1,583	1,821	1,272	1,462	286	330	166	166	21	24	23	26	15	17
67	1,583	1,821	1,272	1,462	286	330	166	166	21	24	23	26	15	17
68	1,653	1,901	1,326	1,525	299	345	166	166	22	25	24	28	15	17
69	1,723	1,983	1,380	1,588	314	362	166	166	23	26	25	29	16	18
70	1,793	2,062	1,435	1,650	324	372	166	166	23	27	26	30	16	19
71	1,854	2,132	1,483	1,707	339	391	166	166	24	28	27	31	17	19
72	1,915	2,202	1,533	1,763	356	409	166	166	25	29	28	32	17	20
73	1,977	2,273	1,581	1,819	371	428	166	166	26	30	28	33	18	20
74	2,038	2,344	1,630	1,876	387	445	166	166	27	31	29	33	19	20
75	2,101	2,416	1,681	1,933	404	463	166	166	27	32	30	34	19	21
76	2,162	2,487	1,733	1,991	422	486	166	166	28	33	31	35	20	22
77	2,225	2,558	1,784	2,052	442	509	166	166	29	33	32	37	20	22
78	2,291	2,634	1,838	2,114	463	533	166	166	30	34	33	38	20	23
79	2,357	2,711	1,893	2,177	485	557	166	166	31	35	33	39	20	23
80	2,425	2,788	1,950	2,242	506	581	166	166	32	37	34	40	21	24
81	2,497	2,872	2,012	2,314	527	605	166	166	32	37	35	41	21	25
82	2,570	2,956	2,076	2,387	549	631	166	166	33	38	35	42	22	25
83	2,647	3,045	2,143	2,465	572	658	166	166	33	39	37	43	22	26
84	2,727	3,136	2,211	2,543	595	684	166	166	34	40	38	44	23	27
85	2,807	3,227	2,280	2,623	619	711	166	166	35	41	39	45	24	27
86	2,893	3,327	2,355	2,708	639	736	166	166	35	42	40	46	24	28
87	2,980	3,427	2,431	2,796	661	760	166	166	37	43	41	47	25	29
88	3,070	3,530	2,509	2,885	683	785	166	166	38	44	42	48	25	29
89	3,156	3,630	2,584	2,971	704	809	166	166	39	45	43	49	26	30
90	3,241	3,727	2,658	3,056	725	833	166	166	40	46	44	50	27	31
91	3,320	3,819	2,729	3,138	744	855	166	166	41	47	45	51	27	31
92	3,395	3,904	2,795	3,214	761	875	166	166	41	47	45	51	27	32
93	3,464	3,985	2,857	3,286	777	894	166	166	42	47	46	52	28	32
94	3,535	4,065	2,920	3,358	793	912	166	166	42	48	47	53	28	32
95	3,607	4,148	2,984	3,433	809	932	166	166	43	48	47	53	28	33
96	3,679	4,231	3,044	3,501	826	950	166	166	44	49	47	54	29	33
97	3,753	4,315	3,104	3,571	843	969	166	166	45	50	48	56	30	33
98	3,827	4,402	3,168	3,643	860	989	166	166	46	52	49	57	30	34
99	3,903	4,490	3,231	3,715	876	1,008	166	166	46	53	50	58	31	35

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

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

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

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

Attained Age	Base Plan		Base Plan Part B Copay		Part A Ded Rider		Part B Ded Rider		Part B Excess Rider		Additional Home Care		Foreign Travel Rider	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-64	3,509	4,035	2,818	3,241	635	731	166	166	47	54	51	59	32	36
65	1,170	1,345	939	1,081	212	243	166	166	16	18	17	20	11	13
66	1,170	1,345	939	1,081	212	243	166	166	16	18	17	20	11	13
67	1,170	1,345	939	1,081	212	243	166	166	16	18	17	20	11	13
68	1,221	1,404	980	1,127	222	254	166	166	17	19	18	21	11	13
69	1,273	1,464	1,020	1,172	232	267	166	166	17	20	19	21	12	13
70	1,324	1,523	1,060	1,219	239	275	166	166	17	20	19	22	12	13
71	1,370	1,575	1,096	1,260	251	288	166	166	18	21	20	23	13	14
72	1,415	1,627	1,132	1,302	263	303	166	166	19	21	21	24	13	14
73	1,460	1,680	1,168	1,343	274	315	166	166	19	22	21	24	13	15
74	1,505	1,731	1,205	1,385	286	329	166	166	20	23	21	24	13	16
75	1,552	1,785	1,242	1,428	299	343	166	166	21	23	22	25	14	16
76	1,597	1,837	1,279	1,472	312	359	166	166	21	24	23	26	14	17
77	1,643	1,890	1,318	1,515	327	375	166	166	21	24	24	27	15	17
78	1,691	1,946	1,358	1,561	342	393	166	166	22	25	24	28	15	17
79	1,741	2,002	1,398	1,608	357	412	166	166	23	26	24	28	16	17
80	1,791	2,060	1,440	1,657	373	430	166	166	23	27	25	29	16	18
81	1,845	2,121	1,486	1,709	389	448	166	166	24	27	26	30	16	18
82	1,898	2,183	1,533	1,763	405	466	166	166	24	28	27	30	17	19
83	1,955	2,248	1,582	1,820	423	486	166	166	24	28	27	32	17	19
84	2,014	2,316	1,634	1,878	439	506	166	166	25	29	28	32	17	20
85	2,074	2,384	1,684	1,937	457	526	166	166	26	30	28	33	17	21
86	2,136	2,458	1,740	2,000	472	543	166	166	27	30	29	34	18	21
87	2,201	2,531	1,795	2,065	488	562	166	166	27	32	30	35	18	21
88	2,267	2,608	1,853	2,131	505	580	166	166	28	32	32	36	19	21
89	2,332	2,681	1,909	2,195	520	598	166	166	28	33	32	36	19	22
90	2,394	2,753	1,963	2,258	536	616	166	166	29	34	32	37	20	23
91	2,453	2,820	2,015	2,318	550	632	166	166	29	35	33	38	20	23
92	2,508	2,884	2,065	2,374	562	646	166	166	30	35	33	38	21	23
93	2,560	2,943	2,111	2,427	574	660	166	166	30	36	34	39	21	24
94	2,611	3,003	2,157	2,481	586	674	166	166	32	36	34	40	21	24
95	2,665	3,064	2,204	2,535	598	687	166	166	32	36	35	40	21	24
96	2,717	3,125	2,248	2,586	611	702	166	166	32	37	36	40	21	24
97	2,772	3,188	2,294	2,637	623	716	166	166	33	38	36	41	22	25
98	2,827	3,251	2,340	2,691	635	731	166	166	33	39	36	42	22	25
99	2,884	3,316	2,386	2,744	648	744	166	166	34	39	37	43	23	26

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

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

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

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

Attained Age	Base Plan		Base Plan Part B Copay		Part A Ded Rider		Part B Ded Rider		Part B Excess Rider		Additional Home Care		Foreign Travel Rider	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-64	4,035	4,640	3,241	3,726	731	840	166	166	54	62	59	67	36	41
65	1,345	1,547	1,081	1,242	243	280	166	166	18	21	20	22	13	14
66	1,345	1,547	1,081	1,242	243	280	166	166	18	21	20	22	13	14
67	1,345	1,547	1,081	1,242	243	280	166	166	18	21	20	22	13	14
68	1,404	1,615	1,127	1,296	254	293	166	166	19	21	21	24	13	14
69	1,464	1,684	1,172	1,349	267	307	166	166	20	22	21	24	13	15
70	1,523	1,751	1,219	1,401	275	316	166	166	20	23	22	25	13	16
71	1,575	1,811	1,260	1,450	288	332	166	166	21	24	23	26	14	16
72	1,627	1,871	1,302	1,498	303	348	166	166	21	24	24	27	14	17
73	1,680	1,931	1,343	1,545	315	363	166	166	22	25	24	28	15	17
74	1,731	1,991	1,385	1,593	329	378	166	166	23	26	24	28	16	17
75	1,785	2,052	1,428	1,642	343	393	166	166	23	27	25	29	16	18
76	1,837	2,112	1,472	1,691	359	413	166	166	24	28	26	30	17	19
77	1,890	2,173	1,515	1,743	375	432	166	166	24	28	27	32	17	19
78	1,946	2,237	1,561	1,796	393	453	166	166	25	29	28	32	17	20
79	2,002	2,303	1,608	1,849	412	473	166	166	26	30	28	33	17	20
80	2,060	2,368	1,657	1,905	430	494	166	166	27	32	29	34	18	21
81	2,121	2,440	1,709	1,966	448	514	166	166	27	32	30	35	18	21
82	2,183	2,511	1,763	2,028	466	536	166	166	28	32	30	36	19	21
83	2,248	2,586	1,820	2,094	486	559	166	166	28	33	32	36	19	22
84	2,316	2,664	1,878	2,160	506	581	166	166	29	34	32	37	20	23
85	2,384	2,741	1,937	2,228	526	604	166	166	30	35	33	38	21	23
86	2,458	2,826	2,000	2,300	543	625	166	166	30	36	34	39	21	24
87	2,531	2,911	2,065	2,375	562	645	166	166	32	36	35	40	21	24
88	2,608	2,999	2,131	2,451	580	667	166	166	32	37	36	41	21	24
89	2,681	3,083	2,195	2,524	598	687	166	166	33	38	36	42	22	25
90	2,753	3,166	2,258	2,596	616	708	166	166	34	39	37	43	23	26
91	2,820	3,244	2,318	2,665	632	726	166	166	35	40	38	43	23	26
92	2,884	3,316	2,374	2,730	646	743	166	166	35	40	38	43	23	27
93	2,943	3,385	2,427	2,791	660	759	166	166	36	40	39	44	24	27
94	3,003	3,453	2,481	2,853	674	775	166	166	36	41	40	45	24	27
95	3,064	3,523	2,535	2,916	687	792	166	166	36	41	40	45	24	28
96	3,125	3,594	2,586	2,974	702	807	166	166	37	42	40	46	24	28
97	3,188	3,666	2,637	3,034	716	823	166	166	38	43	41	47	25	28
98	3,251	3,739	2,691	3,094	731	840	166	166	39	44	42	48	25	29
99	3,316	3,814	2,744	3,156	744	856	166	166	39	45	43	49	26	30

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

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

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MEDICARE PART A – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	PER BENEFIT PERIOD	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies.	First 60 days	All but $1316	$0 **OR** OPTIONAL PART A DEDUCTIBLE RIDER*	$1316 **OR** $0 $0
	61st - 90th day	All but $329 per day	$329 a day	$0
	91st – 150th day	All but $658 per day	$658 a day	$0
	Beyond the 150 days	$0	100% of Medicare Eligible Expenses**	
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 through 100th day	All but $164.50 a day	Up to $164.50 a day	$0
	101st day and after	$0	$0	All costs
INPATIENT PSYCHIATRIC CARE In patient psychiatric care in a participating psychiatric hospital		190 days per lifetime	175 additional days per lifetime	All costs that exceed the lifetime maximum
BLOOD	First 3 pints	$0	First 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 copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

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

MEDICARE SUPPLEMENT POLICIES – PART B BENEFITS

SERVICES	PER CALENDAR YEAR	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
MEDICAL EXPENSES. Eligible expenses for physician's services, in-patient and out-patient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:	First $183 of Medicare Approved Amounts*	$0	$0 **OR** OPTIONAL PART B DEDUCTIBLE RIDER**	$183 (Part B Deductible) **OR** $0
	Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%; **OR** OPTIONAL PART B EXCESS CHARGES RIDER**	Charges that exceed Medicare Eligible Expenses **OR** $0
BLOOD	First 3 pints	$0	All costs	$0
	Next $183 of Medicare approved amounts*	$0	$183 Part B deductible	
CLINICAL LABORATORY SERVICES – Tests for diagnostic services		100%	$0	$0
HOME HEALTH CARE		100% of charges for visits considered medically necessary by Medicare	40 visits, OR OPTIONAL ADDITIONAL HOME HEALTH CARE RIDER**	All expenses beyond 40 visits per year OR All expenses beyond 365 visits per year.
PREVENTIVE MEDICAL CARE BENEFIT –NOT COVERED BY MEDICARE. Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare	First $120 each calendar year	$0	$120	$0
	Additional charges	$0	$0	All Costs

***Once you have been billed $135 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.**

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

LIMITATIONS AND EXCLUSIONS

- Nursing home care costs beyond what is covered by Medicare and the 30-day skilled nursing care, which includes physical or occupational therapy, speech language pathology or respiratory care.

- Physician charges above Medicare's approved charge.
- Outpatient prescription drugs.
- Most care received outside of the United State of America.
- Dental care, dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for and the cost of eyeglasses or hearing aids, unless eligible under Medicare.
- Coverage for emergency care anywhere or for care received outside the service area if this care is treated differently than other covered benefits.
- Usual, customary, and reasonable (UCR) limitations, in which usual and customary charges apply only to mandated benefits.

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

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

REVIEW AND APPEAL PROCEDURE OF DENIED CLAIMS

1. You, or Your representative, may submit a written request which may be in any form and which may include supporting material for review by Us of the denial of any benefit under this policy.
2. Within 30 days after receiving the request, We will notify the person submitting the request with the results of the review.

Grievance means any dissatisfaction with Our provision of services or claims practices, expressed in writing to Us, by You or on Your behalf.

MEDICARE SUPPLEMENT PREMIUM INFORMATION

ANNUAL PREMIUM

$_____ **BASIC MEDICARE SUPPLEMENT COVERAGE**

OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT POLICY

Each of these riders may be purchased separately.

$_____ ☐ **Rider A - Medicare Part A deductible**
100% of Part A deductible.

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

$_____ ☐ **Rider C – Medicare Part B deductible**
100% of Part B deductible. **Rider 2 - Medicare 50% Part A deductible**
50% of Part A deductible.

$_____ ☐ **Rider D– Medicare Part B Copayment or Coinsurance Rider**
Copayment or coinsurance will be the lesser of $20 per office visit or the Medicare Part B coinsurance and the lesser of $50 per emergency room visit or the Medicare Part B coinsurance in addition to Part B deductible.
B deductible.

$_____ ☐ **Rider E – Medicare Part B Excess Charges Rider**
Covers difference between eligible charge and limiting charge.

$_____ ☐ **Rider F – Foreign Travel Emergency Rider**
After a $250 deductible, covers at least 80% of expenses associated with emergency medical care received outside the U.S.A. during the first 60 days of a trip with a lifetime maximum of $50,000.

$_____ **TOTAL FOR BASIC POLICY AND SELECTED OPTIONAL BENEFITS**

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

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

SUMMARY OF ADDITIONAL COVERAGE REQUIRED BY APPLICABLE WISCONSIN LAWS
SKILLED NURSING FACILITY CARE Thirty (30) days of skilled nursing care in a Skilled Nursing Facility. The facility does not need to be certified by Medicare and the stay does not have to meet Medicare's definition of skilled care. No prior hospitalization is required.
KIDNEY DISEASE Inpatient and outpatient expense for dialysis, transplantation, or donor-related services of kidney disease up to $30,000 in any calendar year.
CHIROPRACTOR The usual and customary expense for services provided by a chiropractor, even if Medicare does not cover the claim.
DIABETES (NON PRESCRIPTION) Coverage for the usual and customary expenses incurred for costs of non-prescription insulin or any other non-prescription equipment and supplies for the treatment of diabetes. This does not include any other outpatient non-prescription or prescription medications. This benefit will not duplicate expenses paid by Medicare.
PREVENTATIVE HEALTH CARE SERVICES Coverage for preventive health care services not covered by Medicare and as determined to be medically appropriate by an attending Physician. Reimbursement shall be for the actual charges up to $120 per calendar year. This benefit will not duplicate expenses paid by Medicare.
HOSPITAL AND AMBULATORY SURGERY CENTER & ANESTHESIA CHARGES FOR DENTAL CARE This benefit is limited to specific conditions and circumstances.
BREAST RECONSTRUCTION POST MASTECTOMY Coverage of breast reconstruction of the affected issue incident to a mastectomy.