800 Crescent Centre Dr.
Suite 200
Franklin, TN 37067
800 264.4000
cont-life.com

OUTLINE OF COVERAGE

MEDICARE SUPPLEMENT INSURANCE

Underwritten by
American Continental Insurance Company

An Aetna Company

AMERICAN CONTINENTAL INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 2
BENEFIT PLANS AVAILABLE: A, B, F, HIGH DEDUCTIBLE F, G, N

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A" Some plans may not be available in your state.

See Outlines of Coverage sections for details about ALL plans

Basic Benefits:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-Approved expenses) or, co-payments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of coinsurance or copayments
Blood: First three pints of blood each year.
Hospice-Part A coinsurance

A	B	C	D	F/F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $[4660]; paid at 100% after limit reached	Out-of-pocket limit $[2330]; paid at 100% after limit reached		

*Plans F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2070] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$2070]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

ANNUAL ATTAINED AGE PREMIUMS

AMERICAN CONTINENTAL INSURANCE COMPANY

Medicare Supplement Policy
2010 Standardized Plan A

Attained	Preferred		Standard	
Age	Female	Male	Female	Male
0-64*	4,561	5,249	N/A	N/A
65	1,246	1,434	1,386	1,593
66	1,246	1,434	1,386	1,593
67	1,246	1,434	1,386	1,593
68	1,299	1,494	1,444	1,660
69	1,356	1,561	1,508	1,733
70	1,412	1,623	1,567	1,804
71	1,466	1,686	1,628	1,873
72	1,516	1,744	1,685	1,936
73	1,564	1,798	1,737	1,998
74	1,610	1,850	1,788	2,055
75	1,650	1,898	1,832	2,107
76	1,688	1,940	1,875	2,157
77	1,724	1,981	1,916	2,202
78	1,756	2,021	1,953	2,244
79	1,788	2,055	1,986	2,283
80	1,818	2,090	2,019	2,320
81	1,842	2,118	2,047	2,353
82	1,866	2,147	2,075	2,386
83	1,892	2,175	2,102	2,418
84	1,915	2,201	2,128	2,446
85	1,936	2,228	2,151	2,475
86	1,959	2,253	2,176	2,503
87	1,980	2,277	2,200	2,528
88	1,999	2,300	2,222	2,555
89	2,019	2,320	2,243	2,579
90	2,036	2,343	2,264	2,601
91	2,053	2,362	2,281	2,624
92	2,068	2,378	2,299	2,645
93	2,082	2,397	2,314	2,662
94	2,098	2,411	2,330	2,679
95	2,109	2,425	2,344	2,695
96	2,122	2,440	2,355	2,711
97	2,134	2,454	2,372	2,727
98	2,146	2,469	2,385	2,743
99	2,160	2,483	2,400	2,758

Modal Factors: Ann:1.0000 Semi: 0.5200 Qtrly: 0.2650 Mthly: 0.0833

The rates above do not include a one time $20 policy fee.

Medicare Supplement Policy
2010 Standardized Plan B

Attained	Preferred		Standard	
Age	Female	Male	Female	Male
0-64*	5,752	6,609	N/A	N/A
65	1,571	1,806	1,746	2,007
66	1,571	1,806	1,746	2,007
67	1,571	1,806	1,746	2,007
68	1,636	1,884	1,819	2,091
69	1,711	1,968	1,900	2,185
70	1,780	2,044	1,975	2,272
71	1,846	2,123	2,052	2,359
72	1,911	2,197	2,123	2,442
73	1,971	2,266	2,189	2,517
74	2,028	2,332	2,253	2,590
75	2,079	2,389	2,309	2,656
76	2,127	2,445	2,363	2,716
77	2,171	2,497	2,413	2,777
78	2,213	2,546	2,459	2,827
79	2,253	2,590	2,503	2,878
80	2,289	2,632	2,543	2,924
81	2,320	2,670	2,579	2,967
82	2,352	2,706	2,615	3,006
83	2,384	2,742	2,648	3,045
84	2,412	2,772	2,682	3,081
85	2,442	2,806	2,712	3,119
86	2,469	2,838	2,743	3,156
87	2,495	2,870	2,770	3,186
88	2,520	2,898	2,799	3,218
89	2,543	2,926	2,825	3,250
90	2,565	2,951	2,851	3,278
91	2,588	2,974	2,874	3,306
92	2,608	2,997	2,897	3,331
93	2,625	3,020	2,917	3,353
94	2,642	3,039	2,935	3,375
95	2,657	3,055	2,954	3,397
96	2,673	3,074	2,970	3,416
97	2,688	3,091	2,988	3,435
98	2,704	3,109	3,005	3,456
99	2,721	3,128	3,024	3,477

'*NOTE: The 0-64 rates are available to those applicants under the age of 65 during the open enrollment/guarantee issue period.

Area Factors:

Tennessee

372, 374, 379, 381..... 1.10
Rest of State..... 0.95

ANNUAL ATTAINED AGE PREMIUMS

AMERICAN CONTINENTAL INSURANCE COMPANY

Medicare Supplement Policy
2010 Standardized Plan F

Attained	Preferred		Standard	
Age	Female	Male	Female	Male
0-64*	6,679	7,683	N/A	N/A
65	1,825	2,100	2,028	2,332
66	1,825	2,100	2,028	2,332
67	1,825	2,100	2,028	2,332
68	1,901	2,185	2,111	2,428
69	1,974	2,271	2,196	2,523
70	2,047	2,354	2,276	2,616
71	2,118	2,436	2,353	2,708
72	2,185	2,514	2,427	2,792
73	2,244	2,580	2,494	2,866
74	2,301	2,648	2,557	2,941
75	2,353	2,708	2,616	3,008
76	2,400	2,758	2,664	3,065
77	2,442	2,806	2,712	3,119
78	2,479	2,851	2,754	3,167
79	2,514	2,891	2,792	3,211
80	2,544	2,927	2,827	3,252
81	2,578	2,966	2,864	3,295
82	2,611	3,003	2,901	3,336
83	2,642	3,039	2,935	3,377
84	2,673	3,074	2,970	3,416
85	2,703	3,108	3,003	3,454
86	2,730	3,140	3,034	3,489
87	2,758	3,172	3,064	3,523
88	2,783	3,200	3,092	3,555
89	2,806	3,229	3,119	3,588
90	2,831	3,254	3,144	3,616
91	2,852	3,278	3,168	3,644
92	2,871	3,300	3,191	3,668
93	2,889	3,322	3,210	3,690
94	2,903	3,340	3,228	3,711
95	2,919	3,358	3,243	3,729
96	2,934	3,374	3,259	3,750
97	2,949	3,390	3,277	3,767
98	2,966	3,408	3,294	3,788
99	2,979	3,426	3,311	3,806

Modal Factors: Ann:1.0000 Semi: 0.5200 Qtrly: 0.2650 Mthly: 0.0833

The rates above do not include a one time $20 policy fee.

Medicare Supplement Policy
2010 Standardized Plan High F

Attained	Preferred		Standard	
Age	Female	Male	Female	Male
0-64*	2,627	3,022	N/A	N/A
65	717	826	797	917
66	717	826	797	917
67	717	826	797	917
68	747	859	831	955
69	777	893	864	993
70	806	927	894	1,029
71	833	959	926	1,065
72	859	988	955	1,097
73	882	1,014	982	1,128
74	905	1,042	1,007	1,157
75	926	1,065	1,029	1,184
76	945	1,084	1,048	1,206
77	960	1,104	1,067	1,227
78	975	1,121	1,083	1,245
79	988	1,137	1,097	1,263
80	1,001	1,151	1,112	1,280
81	1,014	1,166	1,126	1,296
82	1,028	1,180	1,142	1,313
83	1,040	1,196	1,155	1,328
84	1,052	1,210	1,167	1,344
85	1,064	1,223	1,180	1,358
86	1,074	1,236	1,194	1,373
87	1,084	1,247	1,204	1,386
88	1,095	1,259	1,216	1,399
89	1,104	1,270	1,227	1,412
90	1,113	1,280	1,237	1,422
91	1,121	1,290	1,246	1,433
92	1,129	1,298	1,256	1,442
93	1,137	1,307	1,263	1,452
94	1,142	1,314	1,270	1,460
95	1,148	1,321	1,275	1,468
96	1,155	1,327	1,282	1,474
97	1,161	1,334	1,290	1,482
98	1,166	1,341	1,296	1,489
99	1,172	1,347	1,302	1,497

'*NOTE: The 0-64 rates are available to those applicants under the age of 65 during the open enrollment/guarantee issue period.

Area Factors:

Tennessee

372, 374, 379, 381..... 1.10

Rest of State..... 0.95

ANNUAL ATTAINED AGE PREMIUMS

AMERICAN CONTINENTAL INSURANCE COMPANY

Medicare Supplement Policy
2010 Standardized Plan G

Attained	Preferred		Standard	
Age	Female	Male	Female	Male
0-64*	5,848	6,722	N/A	N/A
65	1,598	1,837	1,774	2,041
66	1,598	1,837	1,774	2,041
67	1,598	1,837	1,774	2,041
68	1,664	1,914	1,850	2,127
69	1,739	2,000	1,933	2,223
70	1,808	2,080	2,009	2,311
71	1,877	2,159	2,087	2,399
72	1,943	2,233	2,159	2,482
73	2,004	2,305	2,226	2,561
74	2,062	2,372	2,291	2,634
75	2,114	2,431	2,349	2,700
76	2,162	2,486	2,402	2,763
77	2,209	2,540	2,455	2,822
78	2,252	2,589	2,502	2,876
79	2,291	2,634	2,544	2,926
80	2,327	2,676	2,587	2,973
81	2,361	2,716	2,623	3,018
82	2,392	2,752	2,659	3,057
83	2,424	2,787	2,694	3,097
84	2,454	2,822	2,727	3,135
85	2,483	2,854	2,758	3,172
86	2,510	2,887	2,790	3,208
87	2,537	2,918	2,819	3,242
88	2,563	2,946	2,848	3,275
89	2,587	2,974	2,874	3,305
90	2,609	3,001	2,900	3,335
91	2,632	3,026	2,924	3,362
92	2,650	3,049	2,945	3,387
93	2,670	3,069	2,967	3,411
94	2,687	3,090	2,985	3,433
95	2,703	3,108	3,002	3,454
96	2,718	3,126	3,020	3,473
97	2,735	3,145	3,038	3,494
98	2,751	3,162	3,055	3,514
99	2,767	3,182	3,075	3,536

Modal Factors: Ann:1.0000 Semi: 0.5200 Qtrly: 0.2650 Mthly: 0.0833

The rates above do not include a one time $20 policy fee.

Medicare Supplement Policy
2010 Standardized Plan N

Attained	Preferred		Standard	
Age	Female	Male	Female	Male
0-64*	4,644	5,338	N/A	N/A
65	1,269	1,459	1,410	1,622
66	1,269	1,459	1,410	1,622
67	1,269	1,459	1,410	1,622
68	1,322	1,521	1,470	1,689
69	1,381	1,590	1,536	1,766
70	1,436	1,652	1,596	1,837
71	1,491	1,714	1,656	1,905
72	1,543	1,774	1,714	1,972
73	1,592	1,831	1,769	2,034
74	1,637	1,884	1,820	2,093
75	1,679	1,931	1,865	2,146
76	1,718	1,974	1,908	2,196
77	1,756	2,017	1,950	2,241
78	1,790	2,057	1,987	2,285
79	1,819	2,093	2,021	2,324
80	1,850	2,127	2,055	2,363
81	1,876	2,157	2,085	2,397
82	1,901	2,185	2,112	2,428
83	1,926	2,213	2,139	2,460
84	1,950	2,241	2,165	2,492
85	1,972	2,268	2,190	2,519
86	1,994	2,293	2,216	2,547
87	2,015	2,317	2,240	2,575
88	2,036	2,341	2,260	2,602
89	2,055	2,364	2,283	2,625
90	2,074	2,384	2,304	2,649
91	2,090	2,403	2,321	2,672
92	2,105	2,421	2,340	2,692
93	2,121	2,439	2,355	2,710
94	2,134	2,455	2,373	2,727
95	2,147	2,469	2,387	2,742
96	2,160	2,483	2,399	2,758
97	2,172	2,498	2,413	2,776
98	2,184	2,513	2,427	2,792
99	2,198	2,528	2,443	2,808

'*NOTE: The 0-64 rates are available to those applicants under the age of 65 during the open enrollment/guarantee issue period.

Area Factors:

Tennessee

372, 374, 379, 381..... 1.10
Rest of State..... 0.95

PREMIUM INFORMATION

American Continental Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state. Premiums for this policy will increase due to the increase in your age. Upon attainment of an age requiring a rate increase, the renewal premium for the policy will be the renewal premium then in effect for your attained age. Other policies may be provided with Issue Age rating and do not increase with age. You should compare Issue Age with Attained Age policies.

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

Semi-annual: 0.5200 Quarterly: 0.2650 Monthly EFT: 0.0833.

DISCLOSURES

Use this outline to compare benefits and premium 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 American Continental Insurance Company, P.O.Box 2368, Brentwood, Tennessee 37024. 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 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

The policy may not cover all of your medical costs.

Neither American Continental 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 & You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely any 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.

THE FOLLOWING CHARTS DESCRIBE PLANS A, B, F, HIGH DEDUCTIBLE F, G and N OFFERED BY AMERICAN CONTINENTAL INSURANCE COMPANY.

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1156]	$0	[$1156] (Part A Deductible)
61st thru 90th day	All but [$289] a day	[$289] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$578] a day	[$578] a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$144.50] a day	$0	Up to [$144.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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

**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 [$140] 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 test, durable medical equipment			
First [$140] of Medicare-Approved amounts*	$0	$0	[$140] (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 [$140] of Medicare-Approved amounts*	$0	$0	[$140] (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 [$140] of Medicare Approved amounts*	$0	$0	[$140] (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1156]	[$1156] (Part A Deductible)	$0
61st thru 90th day	All but [$289] a day	[$289] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$578] a day	[$578] a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$144.50] a day	$0	Up to [$144.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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

**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 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

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

* Once you have been billed [$140] 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 test, durable medical equipment			
First [$140] of Medicare-Approved amounts*	$0	$0	[$140] (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 [$140] of Medicare-Approved amounts*	$0	$0	[$140] (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 [$140] of Medicare Approved amounts*	$0	$0	[$140] (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1156]	[$1156] (Part A Deductible)	$0
61st thru 90th day	All but [$289] a day	[$289] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$578] a day	[$578] a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$144.50] a day	Up to [$144.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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

**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 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 [$140] 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 test, durable medical equipment			
First [$140] of Medicare-Approved amounts*	$0	[$140] (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 [$140] of Medicare-Approved amounts*	$0	[$140] (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 [$140] of Medicare Approved amounts*	$0	[$140] (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN F

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

High Deductible 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.

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2070] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are [$2070]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2070] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [$2070] DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1156]	[$1156] (Part A Deductible)	$0
61st thru 90th day	All but [$289] a day	[$289] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$578] a day	[$578] a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$144.50] a day	Up to [$144.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE 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

**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 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.

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed [$140] 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.

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2070] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are [$2070]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2070] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [$2070] DEDUCTIBLE*** 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 test, durable medical equipment			
First [$140] of Medicare-Approved amounts*	$0	[$140] (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 [$140] of Medicare-Approved amounts*	$0	[$140] (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2070] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [$2070] DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First [$140] of Medicare Approved amounts*	$0	[$140] (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2070] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2070] DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1156]	[$1156] (Part A Deductible)	$0
61st thru 90th day	All but [$289] a day	[$289] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$578] a day	[$578] a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$144.50] a day	Up to [$144.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ 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 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 [$140] 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 test, durable medical equipment			
First [$140] of Medicare-Approved amounts*	$0	$0	[$140] (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$140] of Medicare-Approved amounts*	$0	$0	[$140] (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 [$140] of Medicare Approved amounts*	$0	$0	[$140] (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1156]	[$1156] (Part A Deductible)	$0
61st thru 90th day	All but [$289] a day	[$289] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$578] a day	[$578] a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$144.50] a day	Up to [$144.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ 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 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 [$140] 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 test, durable medical equipment			
First [$140] of Medicare-Approved amounts*	$0	$0	[$140] (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-Approved amounts)	$0	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$140] of Medicare-Approved amounts*	$0	$0	[$140] (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment •First [$140] of Medicare Approved amounts*	$0	$0	[$140] (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