

800 Crescent Centre Dr. Suite 200 Franklin, TN 37067 800 264.4000 aetnaseniorproducts.com

Outline of Coverage

Medicare Supplement Insurance

BENEFIT PLANS A, B, F, HIGH DEDUCTIBLE F, G, N

Underwritten by

An Aetna Company

American Continental Insurance Company

Arkansas

05012016

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.

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

1	_		_		_				_	_	_							_							_		
	Z	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			Part A Deductible							Foreign Travel	Emergency						
	Σ	Basic,	including	100% Part B	coinsurance				Skilled	Nursing	Facility	Coinsurance	50% Part A	Deductible						Foreign	Travel	Emergency					
	_	Hospitalization	and preventive	care paid at	100%; other	basic benefits	paid at 75%		75% Skilled	Nursing Facility	Coinsurance		75% Part A	Deductible									Out-of-pocket	limit \$2,480;	paid at 100%	after limit	reached
	¥	Hospitalization	and preventive	care paid at	100%; other	basic benefits	paid at 50%		50% Skilled	Nursing	Facility	Coinsurance	50% Part A	Deductible									Out-of-pocket	limit \$4,960;	paid at 100%	after limit	reached
	o	Basic,	including	100% Part B	coinsurance				Skilled	Nursing	Facility	Coinsurance	Part A	Deductible			Part B	Excess	(100%)	Foreign	Travel	Emergency					
	F/F*	Basic,	including	100% Part B	coinsurance				Skilled	Nursing	Facility	Coinsurance	Part A	Deductible	Part B	Deductible	Part B	Excess	(100%)	Foreign	Travel	Emergency					
	۵	Basic,	·=	100% Part B	coinsurance				Skilled	Nursing	Facility	Coinsurance	Part A	Deductible						Foreign	Travel	Emergency					
nce	ပ	Basic,	including	100% Part B	coinsurance				Skilled	Nursing	Facility	Coinsurance	Part A	Deductible	Part B	Deductible				Foreign	Travel	Emergency					
nospice-Part A comsurance	മ	Basic,	including	100% Part B	coinsurance								Part A	Deductible													
Hospice-F	∢	Basic,		100% Part B	coinsurance																						

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 Plan 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 \$2,180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2,180. Out-of-pocket expenses for this deductible are separate foreign travel emergency deductible.

Arkansas Individual Premium Rates

PLAN A

If applying during the Open Enrollment or GI Period use Preferred Rates Rates Effective 5/1/2016

Zip Codes Beginning with 722

	Mthly	201.59
d Rate	Qtrly	641.30
Standard Rate	Semi	1,258.40
	Annual	2,420.00
	Mthly	181.34
d Rates	Qtrly	576.91
Preferred Rate	Semi	1,132.04
	Annual	2,177.00
Issue	Age	AII

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198

	Mthly	201.59
Rate	Qtrly	641.30
Standard Rat	Semi	1,258.40
	Annual	2,420.00
	Mthly	181.34
Rates	Qtrly	576.91
Preferred Rate	Semi	1,132.04
	Annual	2,177.00
Issue	Age	All

All other Zip Codes Beginning with 720 and 721

	Mthly	170.85
Rate	Qtrly	543.52
Standard Rate	Semi	1,066.52
	Annual	2,051.00
	Mthly	153.69
Rates	Qtrly	488.93
Preferred Rate	Semi	959.40
	Annual	1,845.00
Issue	Age	All

	Mthly	161.27
d Rate	Qtrly	513.04
Standard Rate	Semi	1.006.72
	Annual	461.37 145.03 1.936.00 1.006.72
	Mthly	145.03
d Rates	Qtrly	461.37
Preferred Rates	Semi	905.32
	Annual	All 1.741.00
Issue	Age	All

Arkansas Individual Premium Rates

PLAN B

If applying during the Open Enrollment or GI Period use Preferred Rates Rates Effective 5/1/2016

Zip Codes Beginning with 722

	Mthly	253.98
d Rate	Qtrly	807.99
Standard Rate	Semi	1,585.48
	Annual	3,049.00
	Mthly	228.58
d Rates	Qtrly	727.16
Preferred Rates	Semi	1,426.88
	Annual	2,744.00
Issue	Age	AII

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72142, 72164, 72180, 72183, 72190, 72199

	Mthly	253.98
Rate	Qtrly	807.99
Standard Rat	Semi	1,585.48
	Annual	3,049.00
	Mthly	228.58
Rates	Qtrly	727.16
Preferred Rate	Semi	1,426.88
	Annual	2,744.00
Issue	Age	All

All other Zip Codes Beginning with 720 and 721

	Mthly	215.33
l Rate	Qtrly	685.03
Standard Rate	Semi	1,344.20
	Annual	2,585.00
	Mthly	193.76
d Rates	Qtrly	616.39
Preferred Rate	Semi	1,209.52
	Annual	2,326.00
Issue	Age	AII

	Mthly	203.17
d Rate	Qtrly	646.34
Standard Rat	Semi	1,268.28
	Annual	2,439.00
	Mthly	182.84
Rates	Qtrly	581.68
Preferred Rate	Semi	1,141.40
	Annual	2,195.00
Issue	Age	H

Arkansas Individual Premium Rates

PLAN F

If applying during the Open Enrollment or GI Period use Preferred Rates Rates Effective 5/1/2016

Zip Codes Beginning with 722

	Mthly	287.47
d Rate	Qtrly	914.52
Standard Rate	Semi	1,794.52
	Annual	3,451.00
	Mthly	258.65
d Rates	Qtrly	822.83
Preferred Rates	Semi	1,614.60
	Annual	3,105.00
Issue	Age	Η

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

	Mthly	287.47
d Rate	Qtrly	914.52
Standard Rat	Semi	1,794.52
	Annual	3,451.00
	Mthly	258.65
Rates	Qtrly	822.83
Preferred Rate	Semi	1,614.60
	Annual	3,105.00
Issue	Age	AII

All other Zip Codes Beginning with 720 and 721

	⁄Ithly	243.65
	ĭţ	24
d Rate	Qtrly	775.13
Standard Rate	Semi	1,521.00
	Annual	2,925.00
	Mthly	219.25
d Rates	Qtrly	697.48
Preferred Rate	Semi	1,368.64
	Annual	2,632.00
Issue	Age	AII

	Mthly	229.99
Rate	Qtrly	731.67
Standard Rat	Semi	1,435.72
	Annual	2,761.00
<u>Preferred Rates</u>	Mthly	206.92
	Qtrly	658.26
	Semi	1,291.68
	Annual	2,484.00
Issue	Age	All

Arkansas Individual Premium Rates

PLAN HF

If applying during the Open Enrollment or GI Period use Preferred Rates Rates Effective 5/1/2016

Zip Codes Beginning with 722

	Mthly	112.95
Rate	Qtrly	359.34
Standard Rate	Semi	705.12
	Annual	1,356.00
	Mthly	101.79
d Rates	Qtrly	323.83
Preferred Rate	Semi	635.44
	Annual	1,222.00
Issue	Age	H

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

	Mthly	112.95
Rate	Qtrly	359.34
Standard Rate	Semi	705.12
	Annual	1,356.00
	Mthly	101.79
d Rates	Qtrly	323.83
Preferred Rate	Semi	635.44
	Annual	1,222.00
Issue	Age	Ħ

All other Zip Codes Beginning with 720 and 721

Rate	Mthly	95.71
	Qtrly	304.49
Standard Rate	Semi	597.48
	Annual	1,149.00
	Mthly	86.30
l Rates	Qtrly	274.54
Preferred Rate	Semi	538.72
	Annual	1,036.00
Issue	Age	Η

	Mthly	90.30
Rate	Qtrly	287.26
Standard Rat	Semi	563.68
	Annual	1,084.00
	Mthly	81.47
d Rates	Qtrly	259.17
Preferred Rates	Semi	508.56
	Annual	978.00
Issue	Age	All

Arkansas Individual Premium Rates

PLAN G

If applying during the Open Enrollment or GI Period use Preferred Rates Rates Effective 5/1/2016

Zip Codes Beginning with 722

	Mthly	258.23
d Rate	Qtrly	821.50
Standard Rate	Semi	1,612.00
	Annual	3,100.00
	Mthly	232.49
d Rates	Qtrly	739.62
Preferred Rate	Semi	1,451.32
	Annual	2,791.00
Issue	Age	AII

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

	Mthly	258.23
d Rate	Qtrly	821.50
Standard Rat	Semi	1,612.00
	Annual	3,100.00
	Mthly	232.49
d Rates	Qtrly	739.62
Preferred Rate	Semi	1,451.32
	Annual	2,791.00
Issue	Age	All

All other Zip Codes Beginning with 720 and 721

	>	83
	Mthly	218.83
l Rate	Qtrly	696.16
Standard Rat	Semi	1,366.04
	Annual	2,627.00
	Mthly	197.09
d Rates	Qtrly	656.99
Preferred Rates	Semi	1,230.32
	Annual	2,366.00
Issue	Age	All

	Mthly	206.58
Rate	Qtrly	657.20
Standard Rat	Semi	1,289.60
	Annual	2,480.00
	Mthly	186.01
d Rates	Qtrly	591.75
Preferred Rate	Semi	1,161.16
	Annual	2,233.00
Issue	Age	All

Arkansas Individual Premium Rates

PLAN N

If applying during the Open Enrollment or GI Period use Preferred Rates Rates Effective 5/1/2016

Zip Codes Beginning with 722

	ı	
	Mthly	205.08
d Rate	Qtrly	652.43
Standard Rai	Semi	1,280.24
	Annual	2,462.00
	Mthly	184.43
d Rates	Qtrly	586.71
Preferred Rates	Semi	1,151.28
	Annual	2,214.00
Issue	Age	All

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

	ı	
	Mthly	205.08
d Rate	Qtrly	652.43
Standard Rate	Semi	1,280.24
	Annual	2,462.00
	Mthly	184.43
d Rates	Qtrly	586.71
Preferred Rate	Semi	1,151.28
	Annual	2,214.00
Issue	Age	AII

All other Zip Codes Beginning with 720 and 721

	Mthly	173.85
d Rate	Qtrly	553.06
Standard Rat	Semi	1,085.24
	Annual	2,087.00
	Mthly	156.35
d Rates	Qtrly	497.41
Preferred Rate	Semi	976.04
	Annual	1,877.00
Issue	Age	All

	Mthly	164.10
d Rate	Qtrly	522.05
Standard Rat	Semi	1,024.40
	Annual	1,970.00
	Mthly	147.61
d Rates	Qtrly	469.58
Preferred Rate	Semi	921.44
	Annual	1,772.00
Issue	Age	All

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 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 14770, Lexington, KY 40512-4770. 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) – HOSPITAL 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	PLAN	YOU
LICCRITAL IZATIONS	PAYS	PAYS	PAY
HOSPITALIZATION* Semiprivate room and board,			
general nursing and			
miscellaneous services and			
supplies			
First 60 days	All but \$1,288	\$0	\$1,288
			(Part A
			Deductible)
61st thru 90th day	All but \$322 a day	\$322 a day	\$0
91st day and after			
While using 60 lifetime reserve			
days	All but \$644 a day	\$644 a day	\$0
Once lifetime reserve days are			
used:			
◆Additional 365 days	\$0	100% of Medicare	\$0**
Davis and the Additional 205 davis	\$0	Eligible Expenses	All costs
Beyond the Additional 365 days	φυ	\$0	All COSIS
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 \$161 a day	\$0	Up to \$161 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	All le Control Parities	NA - d'	0.0
You must meet Medicare's	All but very limited	Medicare	\$0
requirements, including a doctor's certification of terminal illness.	copayment/	copayment/	
Certification of terminal limess.	coinsurance for	coinsurance	
	outpatient drugs and inpatient respite care		
	Impalient respite care		

^{**}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 \$166 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 -	17(10	17(10	1741
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 \$166 of Medicare-Approved	\$0	\$0	\$166
amounts*			(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 \$166 of Medicare-Approved	\$0	\$0	\$166
amounts*			(Part B Deductible)
Remainder of Medicare-Approved			
amounts	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES -			
TESTS FOR DIAGNOSTIC	4000/		
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 \$166 of Medicare Approved amounts*	\$0	\$0	\$166 (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 \$1,288	\$1,288	\$0
	AU	(Part A Deductible)	
61st thru 90th day	All but \$322 a day	\$322 a day	\$0
91st day and after			
•While using 60 lifetime reserve	All I- 1 (0 (4 4 1 -	0044 - 1-	ФО.
days	All but \$644 a day	\$644 a day	\$0
Once lifetime reserve days are			
used:	C O	4000/ of Madiagra	
Additional 365 days	\$0	100% of Medicare	\$0**
-Dayand the Additional 265 days	\$0	Eligible Expenses \$0	All costs
Beyond the Additional 365 days SKILLED NURSING FACILITY	φυ	φυ	All COSIS
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	\$0	\$0
	amounts		,
21st thru 100th day	All but \$161 a day	\$0	Up to \$161 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	All but very limited	Medicare	\$0
requirements, including a doctor's	copayment/	copayment/	
certification of terminal illness.	coinsurance for	coinsurance	
	outpatient drugs		
	and inpatient		
	respite care		

^{**}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 \$166 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	\$0	\$0	\$166
First \$166 of Medicare-Approved amounts*	φυ	φυ	(Part B Deductible)
Remainder of Medicare-Approved			(i ait b beductible)
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 \$166 of Medicare-Approved	\$0	\$0	\$166
amounts*			(Part B Deductible)
Remainder of Medicare-Approved			
amounts	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES -			
TESTS FOR DIAGNOSTIC	4000/		
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 \$166 of Medicare Approved amounts*	\$0	\$0	\$166 (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 \$1,288	\$1,288	\$0
		(Part A Deductible)	
61st thru 90th day	All but \$322 a day	\$322 a day	\$0
91st day and after	-	-	
While using 60 lifetime reserve			
days	All but \$644 a day	\$644 a day	\$0
Once lifetime reserve days are	•		
used:			
Additional 365 days	\$0	100% of Medicare	\$0**
,		Eligible Expenses	
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	\$0	\$0
_	amounts		
21st thru 100th day	All but \$161 a day	Up to \$161 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	All but very limited	Medicare	\$0
requirements, including a doctor's	copayment/	copayment/	
certification of terminal illness.	coinsurance for	coinsurance	
	outpatient drugs		
	and inpatient		
	respite care		

^{**}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 \$166 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 -	17(10	17410	17(1
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 \$166 of Medicare-Approved	\$0	\$166	\$0
amounts*		(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 \$166 of Medicare-Approved	\$0	\$166	\$0
amounts*		(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 \$166 of Medicare Approved amounts*	\$0	\$166 (Part B Deductible)	\$0
 Remainder of Medicare Approved amounts 	80%	20%	\$0

PLAN F OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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 \$2,180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are \$2,180. 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.

		AFTER YOU PAY	IN ADDITION TO
		\$2,180	\$2,180
SERVICES	MEDICARE	DEDUCTIBLE***	DEDUCTIBLE***
	PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board,			
general nursing and			
miscellaneous services and			
supplies			
First 60 days	All but \$1,288	\$1,288	\$0
		(Part A Deductible)	
61st thru 90th day	All but \$322 a day	\$322 a day	\$0
91st day and after			
•While using 60 lifetime reserve			
days	All but \$644 a day	\$644 a day	\$0
Once lifetime reserve days are			
used:	40	4000/ 5.84 1	* O**
Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY	ΨΟ	ΨΟ	All COStS
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	\$0	\$0
-	amounts		
21st thru 100th day	All but \$161 a day	Up to \$161 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	All but very limited	Medicare	\$0
requirements, including a doctor's	copayment/	copayment/	
certification of terminal illness.	coinsurance for	coinsurance	
	outpatient drugs		
	and inpatient		
	respite care		

^{**}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 \$166 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 \$2,180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are \$2,180. 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 \$2,180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,180 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		0400	00
First \$166 of Medicare-Approved amounts*	\$0	\$166	\$0
Remainder of Medicare-Approved		(Part B Deductible)	
amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges	Concluding 5575	20110141119 2070	
(Above Medicare-Approved			
amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$166 of Medicare-Approved	\$0	\$166 (Dayl D. Dayley (1915)	\$0
amounts*		(Part B Deductible)	
Remainder of Medicare-Approved amounts	80%	20%	\$0
CLINICAL LABORATORY	00 70	20 /0	ΨΟ
SERVICES -			
TESTS FOR DIAGNOSTIC			
SERVICES	100%	\$0	\$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,180 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$166 of Medicare Approved amounts*	\$0	\$166 (Part B Deductible)	\$0
Remainder of Medicare Approved amounts	80%	20%	\$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2,180 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	20% and amounts
		maximum benefit of	over the \$50,000
		\$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 \$1,288	\$1,288	\$0
,		(Part A Deductible)	
61st thru 90th day	All but \$322 a day	\$322 a day	\$0
91st day and after			
•While using 60 lifetime reserve			
days	All but \$644 a day	\$644 a day	\$0
•Once lifetime reserve days are			
used:			
Additional 365 days	\$0	100% of Medicare	\$0**
		Eligible Expenses	
●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	\$0	\$0
,	amounts		
21st thru 100th day	All but \$161 a day	Up to \$161 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	All but very limited	Medicare	\$0
requirements, including a doctor's	copayment/	copayment/	
certification of terminal illness	coinsurance for	coinsurance	
services	outpatient drugs		
	and inpatient		
	respite care		

^{**}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 \$166 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 -	11110		
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 \$166 of Medicare-Approved	\$0	\$0	\$166
amounts*			(Part B Deductible)
Remainder of Medicare-Approved	Conorolly 900/	Conorolly 200/	\$0
amounts Part P Evenes Charges	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-Approved			
amounts)	\$0	100%	\$0
BLOOD	ΨΟ	100 /0	40
First 3 pints	\$0	All costs	\$0
Next \$166 of Medicare-Approved	\$0	\$0	\$166
amounts*	Ψ		(Part B Deductible)
Remainder of Medicare-Approved			(* 3 2 2 3 3 3 3 3 3 7)
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 \$166 of Medicare	\$0	\$0	\$166
Approved amounts*			(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 Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

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 \$1,288	\$1,288	\$0
,		(Part A Deductible)	
61st thru 90th day	All but \$322 a day	\$322 a day	\$0
91st day and after	-		
While using 60 lifetime reserve			
days	All but \$644 a day	\$644 a day	\$0
Once lifetime reserve days are		-	
used:			
Additional 365 days	\$0	100% of Medicare	\$0**
,		Eligible Expenses	
●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	\$0	\$0
	amounts		
21st thru 100th day	All but \$161 a day	Up to \$161 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	All but very limited	Medicare	\$0
requirements, including a doctor's	copayment/	co-payment/	
certification of terminal illness	coinsurance for	coinsurance	
services	outpatient drugs		
	and inpatient		
	respite care		

^{**}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 \$166 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.

, -	MEDICADE	DI AN	VOII
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES -	IAIO	IAIS	1 71
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 \$166 of Medicare-Approved	\$0	\$0	\$166
amounts*			(Part B Deductible)
Remainder of Medicare-Approved	Generally 80%	Balance, other than	Up to \$20 per office
amounts		up to \$20 per office	visit and up to \$50
		visit and up to \$50	per emergency
		per emergency	room visit. The
		room visit. The	copayment of up to
		co-payment of up to \$50 is waived if the	\$50 is waived if the insured is admitted
		insured is admitted	to any hospital and
		to any hospital and	the emergency visit
		the emergency visit	is covered as a
		is covered as a	Medicare Part A
		Medicare Part A	expense.
		expense.	
Part B Excess Charges			
(Above Medicare-Approved			
amounts)	\$0	0%	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$166 of Medicare-Approved	\$0	\$0	\$166
amounts*			(Part B Deductible)
Remainder of Medicare-Approved			
amounts	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES -			
TESTS FOR DIAGNOSTIC	1000/	40	60
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 \$166 of Medicare	\$0	\$0	\$166
Approved amounts*			(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