800 Crescent Centre Dr.
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aetnaseniorproducts.com

Outline of Coverage

Medicare Supplement Insurance

BENEFIT PLANS A, B, C, F, High Deductible F, G, N

Underwritten by

An Aetna Company **American Continental Insurance Company**

MICHIGAN

AMERICAN CONTINENTAL INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 2
BENEFIT PLANS AVAILABLE: A, B, C, 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 $4960; paid at 100% after limit reached	Out-of-pocket limit $2480; 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 $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2180. 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.

American Continental Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: 480-485,486-489, 492

Female Rates

Attained Age	Preferred						
	Plan A	Plan B	Plan C	Plan F	Plan HF	Plan G	Plan N
Under 65	-	-	3,843	-	-	-	-
65	1,265	1,594	1,846	1,906	750	1,427	1,277
66	1,265	1,594	1,846	1,906	750	1,427	1,277
67	1,265	1,594	1,846	1,906	750	1,427	1,277
68	1,320	1,660	1,927	1,985	780	1,484	1,330
69	1,378	1,737	2,006	2,063	812	1,552	1,389
70	1,431	1,807	2,083	2,139	841	1,613	1,444
71	1,489	1,874	2,155	2,213	871	1,673	1,500
72	1,539	1,939	2,223	2,281	898	1,732	1,551
73	1,586	2,000	2,286	2,343	922	1,787	1,599
74	1,634	2,058	2,346	2,404	945	1,838	1,645
75	1,674	2,111	2,402	2,459	966	1,884	1,689
76	1,713	2,158	2,452	2,506	986	1,928	1,726
77	1,749	2,203	2,504	2,550	1,003	1,968	1,765
78	1,782	2,247	2,550	2,589	1,018	2,007	1,797
79	1,815	2,284	2,592	2,626	1,034	2,041	1,829
80	1,846	2,321	2,626	2,660	1,047	2,076	1,860
81	1,870	2,355	2,661	2,693	1,061	2,104	1,886
82	1,895	2,388	2,692	2,728	1,075	2,135	1,910
83	1,921	2,419	2,725	2,760	1,086	2,159	1,936
84	1,945	2,447	2,753	2,793	1,100	2,188	1,961
85	1,966	2,478	2,781	2,824	1,110	2,214	1,984
86	1,988	2,505	2,810	2,852	1,123	2,237	2,004
87	2,010	2,531	2,836	2,882	1,133	2,261	2,026
88	2,030	2,558	2,862	2,909	1,145	2,284	2,048
89	2,050	2,583	2,886	2,932	1,152	2,306	2,066
90	2,067	2,603	2,912	2,958	1,163	2,326	2,084
91	2,083	2,627	2,935	2,981	1,172	2,347	2,100
92	2,099	2,648	2,956	2,997	1,179	2,362	2,117
93	2,115	2,664	2,972	3,018	1,188	2,379	2,132
94	2,129	2,682	2,992	3,034	1,193	2,397	2,144
95	2,142	2,696	3,009	3,049	1,198	2,410	2,158
96	2,152	2,714	3,024	3,064	1,207	2,424	2,171
97	2,165	2,728	3,042	3,082	1,212	2,438	2,183
98	2,178	2,745	3,059	3,098	1,218	2,452	2,195
99	2,191	2,761	3,076	3,110	1,224	2,467	2,210

Attained Age	Standard						
	Plan A	Plan B	Plan C	Plan F	Plan HF	Plan G	Plan N
Under 65	-	-	4,272	-	-	-	-
65	1,405	1,772	2,051	2,118	833	1,584	1,417
66	1,405	1,772	2,051	2,118	833	1,584	1,417
67	1,405	1,772	2,051	2,118	833	1,584	1,417
68	1,466	1,847	2,142	2,205	868	1,650	1,476
69	1,530	1,928	2,230	2,294	902	1,724	1,545
70	1,589	2,006	2,314	2,377	936	1,790	1,606
71	1,652	2,082	2,395	2,459	966	1,860	1,665
72	1,710	2,154	2,469	2,536	998	1,925	1,724
73	1,764	2,223	2,541	2,604	1,025	1,986	1,778
74	1,815	2,284	2,605	2,672	1,050	2,041	1,830
75	1,860	2,345	2,668	2,733	1,075	2,095	1,875
76	1,902	2,398	2,726	2,785	1,096	2,142	1,918
77	1,946	2,450	2,785	2,833	1,113	2,188	1,961
78	1,984	2,497	2,833	2,876	1,132	2,230	1,998
79	2,017	2,541	2,882	2,917	1,147	2,269	2,032
80	2,050	2,583	2,918	2,955	1,162	2,306	2,066
81	2,078	2,618	2,956	2,992	1,175	2,338	2,097
82	2,105	2,655	2,990	3,030	1,193	2,371	2,123
83	2,135	2,687	3,026	3,066	1,207	2,400	2,151
84	2,159	2,721	3,060	3,102	1,221	2,432	2,177
85	2,184	2,753	3,089	3,136	1,234	2,458	2,203
86	2,210	2,785	3,122	3,169	1,247	2,486	2,228
87	2,234	2,812	3,149	3,199	1,259	2,513	2,253
88	2,255	2,840	3,180	3,231	1,271	2,538	2,273
89	2,276	2,867	3,208	3,258	1,283	2,562	2,296
90	2,299	2,895	3,233	3,284	1,292	2,585	2,316
91	2,315	2,917	3,258	3,309	1,302	2,607	2,335
92	2,335	2,941	3,284	3,332	1,311	2,626	2,352
93	2,348	2,962	3,306	3,354	1,319	2,644	2,368
94	2,365	2,980	3,324	3,372	1,328	2,662	2,385
95	2,380	2,997	3,342	3,387	1,333	2,675	2,398
96	2,392	3,014	3,359	3,405	1,338	2,693	2,412
97	2,406	3,034	3,380	3,422	1,348	2,707	2,426
98	2,420	3,050	3,397	3,442	1,355	2,725	2,439
99	2,436	3,069	3,417	3,457	1,359	2,741	2,456

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

The above rates do not include the $20 application fee.

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)

Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

American Continental Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: 480-485,486-489, 492

Male Rates

Attained Age	Preferred						
	Plan A	Plan B	Plan C	Plan F	Plan HF	Plan G	Plan N
Under 65	-	-	4,419	-	-	-	-
65	1,455	1,833	2,123	2,191	864	1,637	1,466
66	1,455	1,833	2,123	2,191	864	1,637	1,466
67	1,455	1,833	2,123	2,191	864	1,637	1,466
68	1,515	1,913	2,215	2,281	898	1,706	1,529
69	1,585	1,995	2,308	2,373	935	1,784	1,597
70	1,647	2,076	2,394	2,460	968	1,855	1,661
71	1,711	2,154	2,478	2,545	1,002	1,925	1,724
72	1,770	2,230	2,557	2,626	1,034	1,992	1,785
73	1,827	2,300	2,628	2,695	1,061	2,056	1,840
74	1,876	2,367	2,697	2,766	1,087	2,113	1,894
75	1,926	2,426	2,761	2,828	1,110	2,166	1,942
76	1,969	2,482	2,820	2,882	1,133	2,218	1,986
77	2,011	2,536	2,880	2,932	1,152	2,263	2,028
78	2,052	2,585	2,933	2,980	1,172	2,308	2,070
79	2,085	2,629	2,983	3,021	1,188	2,348	2,104
80	2,120	2,673	3,021	3,059	1,202	2,387	2,138
81	2,150	2,709	3,059	3,098	1,218	2,420	2,169
82	2,179	2,747	3,096	3,136	1,234	2,452	2,196
83	2,209	2,784	3,131	3,174	1,247	2,484	2,225
84	2,235	2,814	3,166	3,211	1,264	2,517	2,253
85	2,262	2,849	3,198	3,246	1,277	2,546	2,280
86	2,284	2,880	3,231	3,280	1,291	2,575	2,305
87	2,309	2,912	3,259	3,313	1,304	2,601	2,328
88	2,335	2,942	3,290	3,344	1,315	2,627	2,353
89	2,355	2,970	3,318	3,374	1,328	2,653	2,377
90	2,379	2,996	3,348	3,400	1,336	2,674	2,394
91	2,397	3,021	3,374	3,423	1,348	2,699	2,417
92	2,414	3,042	3,397	3,447	1,357	2,718	2,433
93	2,432	3,066	3,420	3,469	1,364	2,739	2,453
94	2,446	3,085	3,442	3,489	1,372	2,754	2,467
95	2,461	3,102	3,460	3,507	1,379	2,771	2,480
96	2,477	3,120	3,479	3,523	1,385	2,786	2,497
97	2,492	3,138	3,498	3,542	1,395	2,804	2,512
98	2,505	3,155	3,518	3,560	1,401	2,820	2,526
99	2,520	3,174	3,536	3,580	1,408	2,838	2,542

Attained Age	Standard						
	Plan A	Plan B	Plan C	Plan F	Plan HF	Plan G	Plan N
Under 65	-	-	4,911	-	-	-	-
65	1,617	2,036	2,360	2,437	958	1,820	1,631
66	1,617	2,036	2,360	2,437	958	1,820	1,631
67	1,617	2,036	2,360	2,437	958	1,820	1,631
68	1,684	2,122	2,464	2,537	998	1,896	1,699
69	1,759	2,217	2,564	2,636	1,037	1,982	1,775
70	1,830	2,307	2,662	2,733	1,075	2,060	1,846
71	1,900	2,394	2,754	2,828	1,110	2,138	1,916
72	1,966	2,478	2,840	2,917	1,147	2,213	1,984
73	2,028	2,555	2,922	2,995	1,176	2,283	2,044
74	2,085	2,629	2,997	3,072	1,210	2,348	2,104
75	2,141	2,696	3,069	3,144	1,235	2,408	2,157
76	2,189	2,755	3,133	3,201	1,260	2,464	2,207
77	2,236	2,818	3,199	3,258	1,283	2,517	2,253
78	2,277	2,871	3,258	3,309	1,300	2,565	2,299
79	2,318	2,922	3,313	3,355	1,319	2,609	2,336
80	2,355	2,968	3,356	3,396	1,336	2,651	2,375
81	2,390	3,010	3,397	3,443	1,355	2,692	2,408
82	2,421	3,051	3,440	3,485	1,372	2,727	2,441
83	2,456	3,090	3,479	3,529	1,388	2,761	2,473
84	2,483	3,128	3,518	3,568	1,403	2,797	2,504
85	2,515	3,166	3,555	3,607	1,420	2,827	2,531
86	2,541	3,201	3,588	3,645	1,434	2,859	2,561
87	2,565	3,234	3,623	3,680	1,446	2,890	2,588
88	2,594	3,266	3,654	3,715	1,461	2,919	2,616
89	2,618	3,298	3,686	3,748	1,474	2,948	2,638
90	2,640	3,326	3,717	3,777	1,486	2,972	2,663
91	2,663	3,356	3,748	3,807	1,496	2,997	2,685
92	2,683	3,381	3,775	3,831	1,507	3,021	2,706
93	2,703	3,404	3,800	3,855	1,517	3,041	2,723
94	2,720	3,426	3,823	3,877	1,525	3,062	2,742
95	2,735	3,447	3,842	3,896	1,534	3,079	2,756
96	2,752	3,468	3,865	3,915	1,540	3,098	2,772
97	2,768	3,487	3,885	3,935	1,547	3,115	2,790
98	2,785	3,508	3,907	3,957	1,558	3,133	2,806
99	2,800	3,528	3,928	3,977	1,564	3,152	2,825

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

The above rates do not include the $20 application fee.

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)

Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

American Continental Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of State

Female Rates

Attained Age	Preferred						
	Plan A	Plan B	Plan C	Plan F	Plan HF	Plan G	Plan N
Under 65	-	-	3,257	-	-	-	-
65	1,072	1,351	1,564	1,615	636	1,209	1,082
66	1,072	1,351	1,564	1,615	636	1,209	1,082
67	1,072	1,351	1,564	1,615	636	1,209	1,082
68	1,119	1,407	1,633	1,682	661	1,258	1,127
69	1,168	1,472	1,700	1,748	688	1,315	1,177
70	1,213	1,531	1,765	1,813	713	1,367	1,224
71	1,262	1,588	1,826	1,875	738	1,418	1,271
72	1,304	1,643	1,884	1,933	761	1,468	1,314
73	1,344	1,695	1,937	1,986	781	1,514	1,355
74	1,385	1,744	1,988	2,037	801	1,558	1,394
75	1,419	1,789	2,036	2,084	819	1,597	1,431
76	1,452	1,829	2,078	2,124	836	1,634	1,463
77	1,482	1,867	2,122	2,161	850	1,668	1,496
78	1,510	1,904	2,161	2,194	863	1,701	1,523
79	1,538	1,936	2,197	2,225	876	1,730	1,550
80	1,564	1,967	2,225	2,254	887	1,759	1,576
81	1,585	1,996	2,255	2,282	899	1,783	1,598
82	1,606	2,024	2,281	2,312	911	1,809	1,619
83	1,628	2,050	2,309	2,339	920	1,830	1,641
84	1,648	2,074	2,333	2,367	932	1,854	1,662
85	1,666	2,100	2,357	2,393	941	1,876	1,681
86	1,685	2,123	2,381	2,417	952	1,896	1,698
87	1,703	2,145	2,403	2,442	960	1,916	1,717
88	1,720	2,168	2,425	2,465	970	1,936	1,736
89	1,737	2,189	2,446	2,485	976	1,954	1,751
90	1,752	2,206	2,468	2,507	986	1,971	1,766
91	1,765	2,226	2,487	2,526	993	1,989	1,780
92	1,779	2,244	2,505	2,540	999	2,002	1,794
93	1,792	2,258	2,519	2,558	1,007	2,016	1,807
94	1,804	2,273	2,536	2,571	1,011	2,031	1,817
95	1,815	2,285	2,550	2,584	1,015	2,042	1,829
96	1,824	2,300	2,563	2,597	1,023	2,054	1,840
97	1,835	2,312	2,578	2,612	1,027	2,066	1,850
98	1,846	2,326	2,592	2,625	1,032	2,078	1,860
99	1,857	2,340	2,607	2,636	1,037	2,091	1,873

Attained Age	Standard						
	Plan A	Plan B	Plan C	Plan F	Plan HF	Plan G	Plan N
Under 65	-	-	3,620	-	-	-	-
65	1,191	1,502	1,738	1,795	706	1,342	1,201
66	1,191	1,502	1,738	1,795	706	1,342	1,201
67	1,191	1,502	1,738	1,795	706	1,342	1,201
68	1,242	1,565	1,815	1,869	736	1,398	1,251
69	1,297	1,634	1,890	1,944	764	1,461	1,309
70	1,347	1,700	1,961	2,014	793	1,517	1,361
71	1,400	1,764	2,030	2,084	819	1,576	1,411
72	1,449	1,825	2,092	2,149	846	1,631	1,461
73	1,495	1,884	2,153	2,207	869	1,683	1,507
74	1,538	1,936	2,208	2,264	890	1,730	1,551
75	1,576	1,987	2,261	2,316	911	1,775	1,589
76	1,612	2,032	2,310	2,360	929	1,815	1,625
77	1,649	2,076	2,360	2,401	943	1,854	1,662
78	1,681	2,116	2,401	2,437	959	1,890	1,693
79	1,709	2,153	2,442	2,472	972	1,923	1,722
80	1,737	2,189	2,473	2,504	985	1,954	1,751
81	1,761	2,219	2,505	2,536	996	1,981	1,777
82	1,784	2,250	2,534	2,568	1,011	2,009	1,799
83	1,809	2,277	2,564	2,598	1,023	2,034	1,823
84	1,830	2,306	2,593	2,629	1,035	2,061	1,845
85	1,851	2,333	2,618	2,658	1,046	2,083	1,867
86	1,873	2,360	2,646	2,686	1,057	2,107	1,888
87	1,893	2,383	2,669	2,711	1,067	2,130	1,909
88	1,911	2,407	2,695	2,738	1,077	2,151	1,926
89	1,929	2,430	2,719	2,761	1,087	2,171	1,946
90	1,948	2,453	2,740	2,783	1,095	2,191	1,963
91	1,962	2,472	2,761	2,804	1,103	2,209	1,979
92	1,979	2,492	2,783	2,824	1,111	2,225	1,993
93	1,990	2,510	2,802	2,842	1,118	2,241	2,007
94	2,004	2,525	2,817	2,858	1,125	2,256	2,021
95	2,017	2,540	2,832	2,870	1,130	2,267	2,032
96	2,027	2,554	2,847	2,886	1,134	2,282	2,044
97	2,039	2,571	2,864	2,900	1,142	2,294	2,056
98	2,051	2,585	2,879	2,917	1,148	2,309	2,067
99	2,064	2,601	2,896	2,930	1,152	2,323	2,081

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

The above rates do not include the $20 application fee.

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)

Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

American Continental Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of State

Male Rates

Attained Age	Preferred						
	Plan A	Plan B	Plan C	Plan F	Plan HF	Plan G	Plan N
Under 65	-	-	3,745	-	-	-	-
65	1,233	1,553	1,799	1,857	732	1,387	1,242
66	1,233	1,553	1,799	1,857	732	1,387	1,242
67	1,233	1,553	1,799	1,857	732	1,387	1,242
68	1,284	1,621	1,877	1,933	761	1,446	1,296
69	1,343	1,691	1,956	2,011	792	1,512	1,353
70	1,396	1,759	2,029	2,085	820	1,572	1,408
71	1,450	1,825	2,100	2,157	849	1,631	1,461
72	1,500	1,890	2,167	2,225	876	1,688	1,513
73	1,548	1,949	2,227	2,284	899	1,742	1,559
74	1,590	2,006	2,286	2,344	921	1,791	1,605
75	1,632	2,056	2,340	2,397	941	1,836	1,646
76	1,669	2,103	2,390	2,442	960	1,880	1,683
77	1,704	2,149	2,441	2,485	976	1,918	1,719
78	1,739	2,191	2,486	2,525	993	1,956	1,754
79	1,767	2,228	2,528	2,560	1,007	1,990	1,783
80	1,797	2,265	2,560	2,592	1,019	2,023	1,812
81	1,822	2,296	2,592	2,625	1,032	2,051	1,838
82	1,847	2,328	2,624	2,658	1,046	2,078	1,861
83	1,872	2,359	2,653	2,690	1,057	2,105	1,886
84	1,894	2,385	2,683	2,721	1,071	2,133	1,909
85	1,917	2,414	2,710	2,751	1,082	2,158	1,932
86	1,936	2,441	2,738	2,780	1,094	2,182	1,953
87	1,957	2,468	2,762	2,808	1,105	2,204	1,973
88	1,979	2,493	2,788	2,834	1,114	2,226	1,994
89	1,996	2,517	2,812	2,859	1,125	2,248	2,014
90	2,016	2,539	2,837	2,881	1,132	2,266	2,029
91	2,031	2,560	2,859	2,901	1,142	2,287	2,048
92	2,046	2,578	2,879	2,921	1,150	2,303	2,062
93	2,061	2,598	2,898	2,940	1,156	2,321	2,079
94	2,073	2,614	2,917	2,957	1,163	2,334	2,091
95	2,086	2,629	2,932	2,972	1,169	2,348	2,102
96	2,099	2,644	2,948	2,986	1,174	2,361	2,116
97	2,112	2,659	2,964	3,002	1,182	2,376	2,129
98	2,123	2,674	2,981	3,017	1,187	2,390	2,141
99	2,136	2,690	2,997	3,034	1,193	2,405	2,154

Attained Age	Standard						
	Plan A	Plan B	Plan C	Plan F	Plan HF	Plan G	Plan N
Under 65	-	-	4,162	-	-	-	-
65	1,370	1,725	2,000	2,065	812	1,542	1,382
66	1,370	1,725	2,000	2,065	812	1,542	1,382
67	1,370	1,725	2,000	2,065	812	1,542	1,382
68	1,427	1,798	2,088	2,150	846	1,607	1,440
69	1,491	1,879	2,173	2,234	879	1,680	1,504
70	1,551	1,955	2,256	2,316	911	1,746	1,564
71	1,610	2,029	2,334	2,397	941	1,812	1,624
72	1,666	2,100	2,407	2,472	972	1,875	1,681
73	1,719	2,165	2,476	2,538	997	1,935	1,732
74	1,767	2,228	2,540	2,603	1,025	1,990	1,783
75	1,814	2,285	2,601	2,664	1,047	2,041	1,828
76	1,855	2,335	2,655	2,713	1,068	2,088	1,870
77	1,895	2,388	2,711	2,761	1,087	2,133	1,909
78	1,930	2,433	2,761	2,804	1,102	2,174	1,948
79	1,964	2,476	2,808	2,843	1,118	2,211	1,980
80	1,996	2,515	2,844	2,878	1,132	2,247	2,013
81	2,025	2,551	2,879	2,918	1,148	2,281	2,041
82	2,052	2,586	2,915	2,953	1,163	2,311	2,069
83	2,081	2,619	2,948	2,991	1,176	2,340	2,096
84	2,104	2,651	2,981	3,024	1,189	2,370	2,122
85	2,131	2,683	3,013	3,057	1,203	2,396	2,145
86	2,153	2,713	3,041	3,089	1,215	2,423	2,170
87	2,174	2,741	3,070	3,119	1,225	2,449	2,193
88	2,198	2,768	3,097	3,148	1,238	2,474	2,217
89	2,219	2,795	3,124	3,176	1,249	2,498	2,236
90	2,237	2,819	3,150	3,201	1,259	2,519	2,257
91	2,257	2,844	3,176	3,226	1,268	2,540	2,275
92	2,274	2,865	3,199	3,247	1,277	2,560	2,293
93	2,291	2,885	3,220	3,267	1,286	2,577	2,308
94	2,305	2,903	3,240	3,286	1,292	2,595	2,324
95	2,318	2,921	3,256	3,302	1,300	2,609	2,336
96	2,332	2,939	3,275	3,318	1,305	2,625	2,349
97	2,346	2,955	3,292	3,335	1,311	2,640	2,364
98	2,360	2,973	3,311	3,353	1,320	2,655	2,378
99	2,373	2,990	3,329	3,370	1,325	2,671	2,394

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

The above rates do not include the $20 application fee.

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)

Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

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 annually 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.

HOUSEHOLD DISCOUNT

In order to be eligible for the Household discount under an American Continental Insurance Company Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently be covered by an American Continental Insurance Company Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; or (b) be someone with whom you are in a civil union partnership; and (c) be someone with whom you have continuously resided for the past 12 months. The household discount will only be applicable if a policy for each applicant is issued. The discounted rate will be 5 percent lower than the individual rates.

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 1188, 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, C, 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 PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$0	$1288 (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 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 $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 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 $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			
First $166 of Medicare-Approved amounts*	$0	$0	$166 (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 amounts*	$0	$0	$166 (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	$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 $1288	$1288 (Part A Deductible)	$0
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 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 $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 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 $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			
First $166 of Medicare-Approved amounts*	$0	$0	$166 (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 amounts*	$0	$0	$166 (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	$0	$166 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN C

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 $1288	$1288 (Part A Deductible)	$0
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 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 $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 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 C

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			
First $166 of Medicare-Approved amounts*	$0	$166 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	$0	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$166 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN C

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 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 $1288	$1288 (Part A Deductible)	$0
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 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 $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 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 $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			
First $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$166 (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 $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 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 $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2180. 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 $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A Deductible)	$0
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 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 $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 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 $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 $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2180. 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 $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 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 $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$166 (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 $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 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 $2180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2180 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 $1288	$1288 (Part A Deductible)	$0
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 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 $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 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 $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			
First $166 of Medicare-Approved amounts*	$0	$0	$166 (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 amounts*	$0	$0	$166 (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	$0	$166 (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 $1288	$1288 (Part A Deductible)	$0
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 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 $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 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 $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			
First $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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