

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

Missouri

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

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, copayments 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.

Hosnice: Part & coincurance

	z			100% Part B coinsurance, except	coinsurance up to \$20	copayment for office	visit, and up to \$50	copayment for ER		ng Facility Coinsurance	, A	Coinsurance	50% Part A Part A Deductible	Deductible							Emergency	Emergency					
		Hospitalization Basic,	and preventive including			basic benefits	paid at 75%			Nursing Facility Nursing	Coinsurance Facility	Coins	75% Part A 50% F	Deductible Deduc						Foreign	Travel	Emer	ket	limit \$2480;	paid at 100%	limit	ned
	×		è		100%; other 100%	~			led	Nursing Nurs		Coinsurance	50% Part A 75%	Deductible Dedu											paid at 100% paid		reached reached
	IJ			100% Part B ci	coinsurance 1	ā	ă			Nursing	Facility F	Coinsurance	Part A 5	Deductible D			Part B	Excess	(100%)	Foreign	Travel	Emergency		<u>=</u>	ā	IJ	Le
	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,	including	100% Part B	coinsurance				Skilled	Nursing	Facility	Coinsurance	Part A	Deductible						Foreign	Travel	Emergency					
ince	ပ	Basic,	including	100% Part B	coinsurance				Skilled	Nursing	Facility	Coinsurance	Part A	Deductible	Part B	Deductible				Foreign	Travel	Emergency					
Hospice: Part A coinsurance	ш	Basic,	including	100% Part B	coinsurance								Part A	Deductible													
Hospice: F	A	Basic,	including	100% Part B	coinsurance																						

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 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 \$2180 separate foreign travel emergency deductible.

American Continental Insurance Company Annual Issue Age Premiums For Use in ZIP Codes: Rest of State Female Rates

Rates Effective 7/1/2016

Plan A Plan B Plan F Plan F Plan F Plan F Plan S S47 S51 3,847 S55 S,847 S55 S,847 S55 S,215 S,217 S,218 S,217 S,216 S,217 S,216 S,217 S,216 S,217 S,216 S,217 S,216 2,216 3,	IF Plan G 0 1,941 0 1,643 0 1,643 0 1,643 0 1,643 1 1,643 1 1,643 1 1,643 1 1,643 1 1,583 1 1,741 7 1,783 1 1,833 1 1,833 1 1,833 1 1,907 3 1,907 3 1,907 3 1,907 9 1,940 5 1,907 8 2,009 2 2,009 2 2,009 2 2,049 6 2,068	2,638 2,117 2,117 2,117 2,117 2,117 2,181 2,247 2,247 2,247 2,245 2,245 2,245 2,245 2,502 2,502 2,502 2,502 2,502 2,502 2,502	Age Under 65 65 66 69 69 73 73 73 73 75 75	Plan A N/A 2,452 2,452 2,452 2,452 2,521 2,599	Plan B N/A 3,091 3,091	Plan F N/A 3,571	Plan HF N/A 1, 213 1, 213	Plan G N/A 1 <i>82</i> 5	Plan N N/A
2,724 3,521 3,847 2,208 2,783 3,215 2,208 2,783 3,215 2,208 2,783 3,215 2,208 2,859 3,301 2,342 2,948 3,382 2,404 3,101 3,535 2,404 3,101 3,535 2,464 3,101 3,535 2,464 3,101 3,535 2,463 3,101 3,536 2,564 3,231 3,770 2,564 3,231 3,736 2,564 3,331 3,770 2,565 3,371 3,770 2,645 3,371 3,770 2,675 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837		2,638 2,117 2,117 2,117 2,117 2,181 2,247 2,363 2,465 2,465 2,465 2,568 2,568 2,568 2,568 2,568 2,672	Under 65 65 66 69 69 71 71 73 73 75 75	N/A 2,452 2,452 2,452 2,521 2,529	N/A 3,091 3,091	N/A 3,571	N/A 1,213 1,213	N/A 1 875	N/A 2 2 5 4
2,208 2,783 3,215 2,208 2,783 3,215 2,208 2,783 3,215 2,208 2,783 3,215 2,273 2,859 3,301 2,342 2,948 3,382 2,404 3,030 3,460 2,464 3,101 3,535 2,564 3,101 3,535 2,564 3,121 3,599 2,564 3,123 3,647 2,564 3,121 3,599 2,564 3,121 3,596 2,564 3,231 3,736 2,564 3,231 3,736 2,564 3,231 3,736 2,675 3,437 3,667 2,675 3,437 3,837 2,702 3,437 3,837 2,772 3,437 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,925		2,117 2,117 2,117 2,117 2,181 2,247 2,363 2,363 2,363 2,365 2,568 2,568 2,568 2,568 2,568 2,672	69 69 69 60 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	2,452 2,452 2,452 2,521 2,599	3,091 3,091	3,571	1,213 1,213	1 875	7 2 5 4
2,208 2,783 3,215 2,208 2,783 3,215 2,273 2,859 3,301 2,342 2,948 3,382 2,404 3,030 3,460 2,464 3,101 3,535 2,464 3,101 3,535 2,564 3,101 3,535 2,564 3,121 3,599 2,564 3,231 3,736 2,564 3,231 3,736 2,665 3,231 3,736 2,645 3,371 3,736 2,645 3,371 3,736 2,675 3,437 3,837 2,702 3,437 3,837 2,772 3,437 3,837 2,772 3,437 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,501 3,837 2,783 3,559 3,955 2,804 3,593 3,955 2,803 3,9513 4,01		2,117 2,117 2,181 2,247 2,265 2,363 2,363 2,365 2,568 2,568 2,568 2,568 2,502 2,502 2,502 2,502 2,502 2,502 2,502 2,502 2,503	68 67 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	2,452 2,452 2,521 2,599	3,091	1 1 1	1,213	1,040	10017
2,208 2,783 3,215 2,273 2,845 3,301 2,342 2,948 3,382 2,404 3,030 3,460 2,464 3,101 3,535 2,518 3,171 3,599 2,564 3,230 3,647 2,564 3,231 3,736 2,665 3,331 3,736 2,675 3,371 3,770 2,675 3,371 3,770 2,675 3,371 3,770 2,675 3,371 3,770 2,675 3,437 3,837 2,772 3,402 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,782 3,559 3,923 2,804 3,553 3,925 2,803 3,553 3,955 2,804 3,550 3,935 2,869 3,613 4,018 2,869 3,613 4,018		2,117 2,181 2,247 2,247 2,305 2,416 2,416 2,416 2,465 2,416 2,502 2,502 2,503 2,645 2,645	69 69 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	2,452 2,521 2,599		3,5/1		1,825	2,354
2,273 2,859 3,301 2,342 2,948 3,382 2,404 3,030 3,460 2,464 3,101 3,535 2,518 3,171 3,599 2,564 3,231 3,756 2,665 3,231 3,736 2,665 3,331 3,736 2,675 3,371 3,770 2,675 3,371 3,770 2,675 3,371 3,770 2,772 3,440 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,782 3,559 3,923 2,804 3,553 3,955 2,869 3,513 4,018 2,869 3,613 4,018		2,181 2,247 2,247 2,305 2,363 2,416 2,465 2,416 2,541 2,541 2,568 2,645 2,645 2,672	68 69 72 73 75 75 75 75 75	2,521 2,599	3,091	3,571	1, 213	1,825	2,354
2,342 2,948 3,382 2,404 3,030 3,460 2,464 3,101 3,535 2,518 3,171 3,599 2,564 3,230 3,647 2,665 3,231 3,736 2,666 3,284 3,696 2,675 3,371 3,770 2,675 3,371 3,770 2,675 3,371 3,770 2,772 3,402 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,782 3,559 3,923 2,804 3,553 3,955 2,803 3,559 3,955 2,869 3,613 4,018		2,247 2,305 2,305 2,416 2,416 2,465 2,541 2,568 2,568 2,568 2,645 2,645	69 7 7 7 2 2 2 7 7 7 7 7 7 7 7 7 7 7 7 7 7	2,599	3,175	3,665	1,245	1,876	2,424
2,404 3,030 3,460 2,464 3,101 3,535 2,518 3,171 3,599 2,564 3,230 3,647 2,606 3,284 3,696 2,675 3,371 3,770 2,675 3,371 3,770 2,675 3,371 3,770 2,675 3,437 3,837 2,772 3,402 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,782 3,559 3,925 2,804 3,559 3,955 2,869 3,613 4,018 2,869 3,613 4,018		2,305 2,363 2,416 2,465 2,568 2,568 2,568 2,568 2,645 2,645	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7		3,274	3,762	1, 279	1,935	2,497
2,464 3,101 3,535 2,518 3,171 3,599 2,564 3,230 3,647 2,606 3,284 3,696 2,645 3,331 3,736 2,645 3,331 3,736 2,645 3,331 3,736 2,645 3,311 3,770 2,647 3,311 3,770 2,647 3,311 3,770 2,675 3,412 3,837 2,728 3,437 3,837 2,772 3,402 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,437 3,837 2,772 3,437 3,837 2,782 3,559 3,923 2,804 3,553 3,955 2,869 3,613 4,018 2,869 3,613 4,018		2,363 2,416 2,465 2,502 2,502 2,502 2,568 2,568 2,568 2,645 2,672	71 27 25 25 25 25 25 27	2,669	3,362	3,846	1, 307	1,985	2,565
2,518 3,171 3,599 2,564 3,230 3,647 2,606 3,284 3,696 2,645 3,331 3,736 2,645 3,331 3,736 2,645 3,331 3,736 2,675 3,371 3,770 2,702 3,402 3,837 2,772 3,402 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,501 3,832 2,804 3,553 3,955 2,809 3,954 3,984 2,869 3,613 4,018		2,416 2,465 2,502 2,541 2,568 2,568 2,568 2,645 2,645	72 73 75 76 75	2,734	3,447	3,928	1, 335	2,035	2,624
2,564 3,230 3,647 2,606 3,284 3,696 2,645 3,331 3,736 2,645 3,331 3,736 2,645 3,311 3,770 2,675 3,417 3,837 2,702 3,402 3,837 2,772 3,417 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,772 3,472 3,837 2,773 3,550 3,925 2,804 3,553 3,955 2,809 3,954 2,869 2,869 3,613 4,018		2,465 2,502 2,541 2,568 2,568 2,596 2,623 2,645 2,645	73 75 76 77	2, 793	3,524	3,999	1, 361	2,081	2,684
2,606 3,284 3,696 2,645 3,331 3,736 2,645 3,331 3,736 2,675 3,371 3,770 2,772 3,402 3,807 2,772 3,407 3,837 2,772 3,407 3,526 3,923 2,804 3,559 3,955 2,849 3,559 3,955 2,849 3,559 3,958 2,849 3,590 3,913 4,018		2,502 2,541 2,568 2,596 2,623 2,645 2,672	74 75 76 77	2,846	3,591	4,055	1, 382	2,120	2,737
2,645 3,331 3,736 2,675 3,371 3,770 2,675 3,371 3,770 2,772 3,402 3,802 2,775 3,477 3,867 2,775 3,477 3,867 2,782 3,501 3,892 2,804 3,559 3,955 2,849 3,559 3,955 2,849 3,559 3,954 2,869 3,613 4,018		2,541 2,568 2,596 2,623 2,645 2,672	75 76 77	2,897	3,649	4,108	1,400	2,156	2,782
2,675 3,371 3,770 2,702 3,402 3,802 2,725 3,417 3,837 2,755 3,472 3,867 2,782 3,501 3,892 2,804 3,559 3,923 2,849 3,559 3,955 2,849 3,550 3,984 2,869 3,613 4,018		2,568 2,596 2,623 2,645 2,672	76 77	2,937	3,701	4,153	1,415	2,186	2,817
2,702 3,402 3,802 2,728 3,437 3,837 2,755 3,472 3,867 2,782 3,501 3,892 2,804 3,528 3,923 2,829 3,559 3,955 2,849 3,559 3,955 2,849 3,590 3,944 2,869 3,613 4,018		2,596 2,623 2,645 2,672	77	2,969	3,746	4,189	1,427	2,212	2,851
2,728 3,437 3,837 2,755 3,472 3,867 2,782 3,501 3,892 2,804 3,528 3,923 2,823 3,559 3,955 2,849 3,559 3,955 2,849 3,590 3,984 2,869 3,613 4,018		2,623 2,645 2,672		3,004	3,781	4,222	1,436	2,233	2,886
2,755 3,472 3,867 3,728 3,501 3,892 2,804 3,528 3,923 2,824 3,559 3,955 2,849 3,559 3,955 2,849 3,590 3,984 2,869 3,613 4,018		2,645 2,672	78	3,034	3,821	4,263	1,446	2,257	2,913
2,782 3,501 3,892 2,804 3,528 3,923 2,804 3,559 3,955 2,849 3,559 3,954 2,869 3,613 4,018 2,869 3,613 4,018		2,672	79	3,061	3,856	4,296	1,453	2,278	2,938
2,804 3,528 3,923 2,823 3,559 3,955 2,823 3,559 3,955 2,849 3,590 3,984 2,869 3,613 4,018 2,869 3,613 4,018			80	3,088	3,893	4,322	1,459	2,296	2,966
2,823 3,559 3,955 3 2,849 3,590 3,984 2,869 3,613 4,018		2,694	81	3,112	3,923	4,358	1,470	2,317	2,992
2,849 3,590 3,984 3 2,869 3,613 4,018 3	5 2,103	2,713	82	3,138	3,955	4,392	1,483	2,337	3,016
2,869 3,613 4,018	5 2,118	2,734	83	3,166	3,987	4,425	1,493	2,355	3,039
	2 2,134	2,758	84	3,188	4,018	4,464	1,503	2,372	3,060
85 2,887 3,639 4,053 1,361	1 2,150	2,774	85	3,208	4,044	4,500	1,511	2,389	3,079
86 2,905 3,663 4,081 1,366	6 2,162	2,789	86	3, 228	4,068	4,534	1,520	2,403	3,099
2,922 3,682 4,110 :		2,806	87	3,247	4,087	4,565	1,527	2,417	3,119
88 2,948 3,717 4,144 1,386	6 2,194	2,834	88	3,276	4,129	4,606	1,541	2,439	3,146
3,750 4,178	8 2,214	2,860	89	3,307	4,165	4,643	1,554	2,461	3,176
90 3,001 3,781 4,214 1,410	0 2,233	2,883	06	3,336	4,204	4,677	1,566	2,484	3,203
3,025 3,815 4,245		2,906	91	3,362	4,238	4,714	1,578	2,504	3,228
92 3,050 3,844 4,274 1,429		2,929	92	3,388	4,271	4,752	1,588	2,522	3,254
93 3,070 3,872 4,301 1,438	8 2,286	2,952	93	3,413	4,300	4,778	1,598	2,541	3,276
94 3,094 3,896 4,321 1,446	6 2,302	2,967	94	3,435	4,328	4,805	1,607	2,556	3,301
95 3,109 3,918 4,345 1,453	3 2,315	2,986	95	3,457	4,356	4,828	1,615	2,570	3,320
96 3,130 3,941 4,368 1,463	3 2,326	3,005	96	3,473	4,379	4,853	1,622	2,586	3,336
97 3,145 3,963 4,391 1,468	8 2,341	3,020	97	3,496	4,403	4,878	1,633	2,601	3,356
98 3,162 3,987 4,413 1,477	7 2,355	3,037	98	3,515	4,430	4,905	1,640	2,617	3,376
99 3,186 4,011 4,434 1,483	3 2,369	3,058	66	3,538	4,456	4,929	1,648	2,632	3,397
Modal Factors: Semi-Annual:	il: 0.5200		Quarterly:	0.2650		Σ	Monthly:	0.0833	

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

To calculate a Household discount: Annual premium x modal factor = modal premium (round to nearest whole cent) Modal premium x .95 = discounted premium

American Continental Insurance Company Annual Issue Age Premiums For Use in ZIP Codes: Rest of State Male Rates

Rates Effective 7/1/2016

Issue			Pref	Preferred			Issue			Sta	Standard		
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,132	4,052	4,423	1, 347	2,232	3,034	Under 65	N/A	N/A	N/A	N/A	N/A	N/A
65	2,539	3,196	3,696	1,256	1,888	2,437	65	2,820	3,552	4,107	1, 394	2,098	2,708
99	2,539	3,196	3,696	1,256	1,888	2,437	99	2,820	3,552	4,107	1, 394	2,098	2,708
67	2,539	3,196	3,696	1,256	1,888	2,437	67	2,820	3,552	4,107	1, 394	2,098	2,708
68	2,610	3,288	3,792	1, 288	1,942	2,507	68	2,902	3,652	4,216	1,432	2,157	2,785
69	2,694	3,395	3,892	1,324	2,003	2,585	69	2,992	3,767	4,322	1,468	2,227	2,872
70	2,762	3,482	3,981	1,354	2,057	2,655	70	3,070	3,868	4,423	1,504	2,285	2,952
71	2,833	3,566	4,067	1, 383	2,105	2,715	71	3,145	3,962	4,519	1,535	2,340	3,020
72	2,895	3,647	4,142	1,410	2,154	2,779	72	3,214	4,053	4,600	1,563	2,392	3,088
73	2,948	3,714	4,194	1,429	2,194	2,832	73	3,276	4,129	4,661	1,587	2,439	3,146
74	2,997	3,778	4,253	1,450	2,231	2,879	74	3,330	4,195	4,724	1,609	2,477	3,200
75	3,041	3,828	4,298	1,465	2,263	2,919	75	3,377	4,255	4,776	1,629	2,513	3,243
76	3,074	3,875	4,334	1,476	2,288	2,954	76	3,417	4,304	4,816	1,640	2,542	3,280
77	3,104	3,915	4,370	1,485	2,312	2,982	77	3,452	4,350	4,855	1,652	2,568	3,313
78	3,138	3,954	4,412	1,496	2,335	3,016	78	3,485	4, 391	4,899	1,661	2,595	3,350
79	3,168	3,990	4,451	1,504	2,358	3,043	79	3,518	4,435	4,940	1,671	2,618	3,378
80	3,196	4,028	4,476	1,513	2,378	3,071	80	3,551	4,474	4,973	1,682	2,643	3,409
81	3,222	4,061	4,512	1,523	2,398	3,094	81	3,580	4,512	5,017	1,691	2,666	3,439
82	3,249	4,094	4,547	1,533	2,418	3,120	82	3,611	4,550	5,050	1,705	2,688	3,467
83	3,274	4,129	4,583	1,544	2,437	3,144	83	3,639	4,586	5,093	1,717	2,708	3,493
84	3,298	4,155	4,622	1,555	2,454	3,169	84	3,665	4,618	5,136	1,728	2,728	3,521
85	3,321	4,183	4,657	1,563	2,472	3,190	85	3,690	4,648	5,174	1, 739	2,747	3,542
86	3,340	4,208	4,690	1,572	2,487	3,209	86	3,713	4,681	5,214	1,747	2,762	3,564
87	3,360	4,235	4,726	1,581	2,500	3,225	87	3,732	4,703	5,249	1,756	2,779	3,585
88	3,395	4,274	4,765	1,596	2,523	3,260	88	3,769	4,748	5,294	1,770	2,805	3,621
89	3,420	4,315	4,807	1,607	2,548	3,288	89	3,802	4,791	5,340	1, 786	2,830	3,652
90	3,456	4,350	4,843	1,619	2,570	3,314	6	3,836	4,833	5,384	1,801	2,855	3,685
91	3,483	4,387	4,879	1,633	2,592	3,344	91	3,868	4,873	5,425	1,815	2,879	3,716
92	3,506	4,419	4,913	1,645	2,610	3,369	92	3,898	4,912	5,460	1,824	2,901	3,743
93	3,534	4,453	4,943	1,654	2,628	3,391	93	3,925	4,945	5,491	1,838	2,920	3,769
94	3,554	4,480	4,973	1,664	2,646	3,415	94	3,950	4,978	5,524	1,849	2,939	3,791
95	3,576	4,506	4,996	1,672	2,661	3,433	95	3,974	5,008	5,552	1,857	2,957	3,814
96	3,597	4,532	5,021	1,680	2,676	3,454	96	3,998	5,036	5,581	1,868	2,974	3,838
97	3,616	4,558	5,047	1,689	2,694	3,474	97	4,019	5,066	5,608	1,875	2,991	3,859
98	3,639	4,585	5,073	1,698	2,708	3,493	86	4,045	5,095	5,638	1,887	3,009	3,883
66	3,661	4,611	5,098	1, 705	2,724	3,516	66	4,067	5,123	5,666	1, 895	3,027	3,905
										Í			

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.

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American Continental Insurance Company Annual Issue Age Premiums For Use in ZIP Codes: 630, 631, 633, 640, 641 Female Rates

Rates Effective 7/1/2016

13340			Pret	Preterred			Issue			Sta	Standard		
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,881	3,725	4,069	1,238	2,053	2,791	Under 65	N/A	N/A	N/A	N/A	N/A	N/A
65	2, 335	2,944	3,400	1,153	1,738	2,240	65	2,594	3,269	3,777	1, 283	1,931	2,489
99	2,335	2,944	3,400	1,153	1,738	2,240	99	2,594	3,269	3,777	1, 283	1,931	2,489
67	2,335	2,944	3,400	1,153	1,738	2,240	67	2,594	3,269	3,777	1, 283	1,931	2,489
68	2,405	3,024	3,491	1,186	1,786	2,307	68	2,666	3,358	3,876	1,317	1,984	2,564
69	2,477	3,119	3,577	1,217	1,841	2,377	69	2,749	3,463	3,979	1, 353	2,047	2,641
70	2,543	3,204	3,660	1,245	1,891	2,438	70	2,823	3,556	4,068	1, 383	2,100	2,713
71	2,606	3,280	3,739	1,271	1,937	2,499	71	2,892	3,645	4,155	1,412	2,153	2,775
72	2,663	3,354	3,807	1,295	1,981	2,555	72	2,955	3,727	4,230	1,440	2,201	2,839
73	2,712	3,417	3,858	1,315	2,017	2,607	73	3,011	3,798	4,289	1,462	2,242	2,895
74	2,757	3,474	3,909	1,332	2,052	2,647	74	3,065	3,860	4,345	1,481	2,280	2,943
75	2,797	3,523	3,951	1,348	2,080	2,687	75	3,106	3,915	4,392	1,497	2,312	2,980
76	2,829	3,565	3,988	1,360	2,104	2,716	76	3,141	3,962	4,431	1,509	2,340	3,015
77	2,858	3,598	4,022	1,366	2,125	2,746	77	3,177	4,000	4,466	1,519	2,362	3,053
78	2,885	3,636	4,058	1,375	2,147	2,774	78	3,209	4,041	4,509	1,529	2,387	3,081
79	2,914	3,672	4,090	1,384	2,167	2,797	79	3,237	4,079	4,544	1,537	2,409	3,108
80	2,943	3,703	4,116	1,392	2,187	2,826	80	3,266	4,117	4,572	1,543	2,429	3,137
81	2,966	3,731	4,149	1,401	2,206	2,849	81	3, 291	4,149	4,609	1,554	2,451	3,165
82	2,985	3,764	4,183	1,412	2,224	2,870	82	3,319	4,183	4,645	1,569	2,472	3,190
83	3,013	3,797	4,214	1,422	2,241	2,892	83	3,348	4,217	4,681	1,580	2,490	3,214
84	3,035	3,821	4,249	1,430	2,257	2,917	84	3,372	4,249	4,721	1,590	2,509	3,236
85	3,054	3,849	4,287	1,440	2,274	2,934	85	3, 394	4,277	4,760	1,598	2,527	3,257
86	3,072	3,874	4,316	1,444	2,287	2,950	86	3,414	4,303	4,796	1,608	2,542	3,278
87	3,091	3,894	4,347	1,454	2,299	2,968	87	3,434	4,323	4,828	1,615	2,556	3,299
88	3,119	3,931	4,384	1,466	2,321	2,998	88	3,465	4,367	4,872	1,630	2,580	3,328
68	3,149	3,967	4,419	1,478	2,342	3,025	89	3,498	4,406	4,910	1,643	2,603	3,359
6	3,175	4,000	4,457	1,492	2,362	3,049	06	3,529	4,446	4,947	1,657	2,627	3,388
91	3,200	4,035	4,490	1,500	2,383	3,073	91	3,556	4,483	4,986	1,669	2,649	3,414
92	3, 226	4,066	4,521	1,511	2,400	3,098	92	3,584	4,518	5,026	1,680	2,668	3,442
93	3,247	4,095	4,550	1,521	2,418	3,122	93	3,610	4,549	5,053	1,691	2,687	3,465
94	3, 273	4,121	4,571	1,529	2,434	3,138	94	3,633	4,578	5,082	1,700	2,704	3,491
95	3, 288	4,144	4,596	1,537	2,449	3,158	95	3,656	4,607	5,106	1,708	2,718	3,511
96	3,311	4,168	4,620	1,548	2,461	3,178	96	3,673	4,632	5,133	1,716	2,736	3,529
97	3,326	4,192	4,644	1,553	2,476	3,194	97	3,698	4,657	5,159	1,727	2,751	3,550
98	3,344	4,217	4,667	1,562	2,490	3,212	98	3,718	4,686	5,188	1,735	2,768	3,571
66	3, 369	4,243	4,689	1,569	2,506	3,234	66	3,742	4,714	5,213	1,744	2,784	3,593
Modal Eactors.				•									

The above rates do not indude 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.

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American Continental Insurance Company Annual Issue Age Premiums For Use in ZIP Codes: 630, 631, 633, 640, 641 Male Rates

Rates Effective 7/1/2016

Age Pla Under 65 3, 65 2,	Plan A I	-											
		Plan B	Plan F	Plan HF	Plan G	Plan N	Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
	3,313	4,286	4,678	1,425	2,361	3,209	Under 65	N/A	N/A	N/A	N/A	N/A	N/A
	2,685	3,380	3,909	1,329	1,997	2,577	65	2,983	3,757	4,344	1,474	2,219	2,864
66 2,	2,685	3,380	3,909	1, 329	1,997	2,577	99	2,983	3,757	4,344	1,474	2,219	2,864
67 2,	2,685	3,380	3,909	1, 329	1,997	2,577	67	2,983	3,757	4,344	1,474	2,219	2,864
68 2,	2,761	3,478	4,011	1, 362	2,054	2,652	68	3,069	3,863	4,459	1,515	2,281	2,946
69 2,	2,849	3,590	4,116	1,400	2,119	2,735	69	3,165	3,984	4,572	1,553	2,355	3,038
70 2,	2,922	3,683	4,211	1,432	2,176	2,808	70	3,247	4,091	4,678	1,591	2,417	3,122
71 2,	2,996	3,772	4,302	1,463	2,226	2,872	71	3,326	4,191	4,780	1,624	2,475	3,194
72 3,	3,062	3,858	4,381	1,492	2,278	2,939	72	3,399	4,287	4,865	1,653	2,530	3,266
73 3,	3,119	3,928	4,436	1,511	2,321	2,995	73	3,465	4,367	4,930	1,679	2,580	3,328
74 3,	3,170	3,996	4,498	1,533	2,360	3,045	74	3,522	4,437	4,996	1,702	2,620	3,385
75 3,	3,216	4,049	4,546	1,550	2,394	3,088	75	3,572	4,500	5,051	1,723	2,658	3,430
76 3,	3,252	4,099	4,584	1,561	2,420	3,124	76	3,615	4,552	5,094	1,735	2,688	3,469
77 3,	3,284	4,140	4,622	1,571	2,445	3,154	77	3,651	4,601	5,135	1,747	2,716	3,505
78 3,	3,319	4,182	4,666	1,582	2,470	3,190	78	3,686	4,644	5,182	1,757	2,745	3,543
79 3,	3,351	4,221	4,708	1,591	2,494	3,219	79	3,721	4,690	5,225	1,768	2,769	3,573
80 3,	3,380	4,260	4,734	1,601	2,516	3,248	80	3,755	4,732	5,260	1,779	2,795	3,606
81 3,	3,408	4,296	4,772	1,610	2,537	3,273	81	3,786	4,772	5,306	1,789	2,819	3,638
82 3,	3,436	4,331	4,809	1,621	2,558	3,300	82	3,819	4,813	5,342	1,803	2,844	3,667
83 3,	3,463	4,367	4,848	1,634	2,577	3,325	83	3,849	4,851	5,387	1,816	2,864	3,695
84 3,	3,488	4,395	4,888	1,645	2,596	3,352	84	3,876	4,884	5,432	1,828	2,885	3,725
85 3,	3,512	4,424	4,926	1,653	2,615	3,374	85	3,903	4,916	5,473	1, 839	2,905	3,747
86 3,	3,533	4,451	4,961	1,663	2,630	3,395	86	3,927	4,951	5,514	1,848	2,922	3,770
87 3,	3,554	4,479	4,998	1,672	2,644	3,411	87	3,947	4,974	5,552	1,857	2,939	3,792
88 3,	3,590	4,521	5,040	1,689	2,669	3,449	88	3,986	5,022	5,599	1,872	2,967	3,830
89 3,	3,617	4,564	5,084	1,700	2,695	3,478	89	4,022	5,068	5,649	1,889	2,993	3,863
90 3,	3,655	4,601	5,123	1,713	2,718	3,506	06	4,057	5,112	5,695	1,905	3,020	3,897
91 3,	3,684	4,640	5,160	1,727	2,741	3,537	91	4,091	5, 155	5,738	1,920	3,045	3,930
92 3,	3,708	4,674	5,196	1,740	2,761	3,563	92	4,123	5, 195	5,775	1,929	3,068	3,959
93 3,	3,738	4,710	5,228	1,749	2,780	3,587	93	4,151	5,231	5,808	1,944	3,089	3,986
	3,759	4,739	5,260	1,760	2,798	3,612	94	4,178	5,266	5,843	1,956	3,109	4,010
95 3,	3,782	4,766	5,284	1,769	2,815	3,631	95	4,203	5, 297	5,872	1,965	3,127	4,034
96 3,	3,805	4,794	5,311	1,777	2,830	3,653	96	4,228	5,326	5,903	1,976	3,146	4,059
97 3,	3,825	4,821	5,338	1,786	2,849	3,674	97	4,250	5,358	5,931	1,983	3,164	4,082
98 3,	3,849	4,850	5,366	1,796	2,864	3,695	86	4,278	5, 389	5,963	1,995	3,182	4,107
99 3,	3,872	4,877	5,392	1,803	2,881	3,719	66	4,302	5,419	5,993	2,004	3,202	4,131

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

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 may be changed for this policy on any premium due date, provided premiums for all policies issued on this form number in your state are also changed. For every nonscheduled premium change, we will give you at least 30 days advance notice in writing of such premium change.

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

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

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; (b) be someone with whom you are in a civil union partnership; or (c) be a permanent resident in your home. 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 and will apply as long as both policies remain in force.

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 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 91st day and after ●While using 60 lifetime reserve	All but \$322 a day	\$322 a day	\$0
 Once lifetime reserve days are used: 	All but \$644 a day	\$644 a day	\$0
•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 21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0 \$0 \$0 \$0	\$0 Up to \$161 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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	\$0	\$0	\$166
amounts*			(Part B Deductible)
Remainder of Medicare-Approved			
amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges			
(Above Medicare-Approved	*^	* 0	All (-
amounts)	\$0	\$0	All costs
BLOOD	\$0	All costs	¢0
First 3 pints Next \$166 of Medicare-Approved	\$0 \$0	\$0	\$0 \$166
amounts*	ΨΟ	ΨΟ	(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 emounte*	\$0	\$0	\$166 (Part B Deductible)
 Approved amounts* Remainder of Medicare Approved amounts 	80%	20%	(Part & Deductible) \$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	\$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:			A O U
 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	All approved	\$0	\$0
First 20 days	All approved amounts	ወ	φυ
21st thru 100th day	All but \$161 a day	\$0	Up to \$161 a day
101st day and after	\$0	\$0	All costs
BLOOD	ΨΟ	ΨΟ	
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		

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	\$0	\$0	\$166
amounts*			(Part B Deductible)
Remainder of Medicare-Approved			
amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges			
(Above Medicare-Approved	*0	A A	
amounts)	\$0	\$0	All costs
BLOOD	¢۵		¢ 0
First 3 pints	\$0 \$0	All costs \$0	\$0 \$166
Next \$166 of Medicare-Approved amounts*	φυ	φυ	(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			
SERVICESMedically necessary skilled care	100%	\$0	\$0
services and medical supplies			
 Durable medical equipment First \$166 of Medicare 	\$0	\$0	\$166
Approved amounts*			(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 \$1288	\$1288	\$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:	# 0	4000/ - (Madiana	0. + +
 Additional 365 days 	\$0	100% of Medicare	\$0**
- Devend the Additional 265 days	\$0	Eligible Expenses	All costs
•Beyond the Additional 365 days SKILLED NURSING FACILITY	φυ	Ф О	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	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		

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	\$0	\$166	\$0
amounts*		(Part B Deductible)	
Remainder of Medicare-Approved	0	0 11 000/	AA
amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges			
(Above Medicare-Approved amounts)	\$0	100%	\$0
BLOOD	φυ	100 /0	φυ
First 3 pints	\$0	All costs	\$0
Next \$166 of Medicare-Approved	\$0	\$166	\$0 \$0
amounts*		(Part B Deductible)	+ -
Remainder of Medicare-Approved			
amounts	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES -			
TESTS FOR DIAGNOSTIC	4000/	¢0	¢o
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 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.

***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.

		AFTER YOU PAY	IN ADDITION TO
		\$2180 DEDUCTION Extra	\$2180 DEDUCTION Ettt
SERVICES	MEDICARE PAYS	DEDUCTIBLE*** PLAN PAYS	DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			IOUTAI
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			ΨŬ
•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	\$0	\$0
	amounts		T -
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	Medicare copayment/ coinsurance	\$0
	and inpatient		
	respite care		

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	\$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	ΨΟ	100 /0	ψυ
First 3 pints	\$0	All costs	\$0
Next \$166 of Medicare-Approved	\$0	\$166	\$0
amounts*		(Part B Deductible)	
Remainder of Medicare-Approved	0.00/	000/	AA
amounts	80%	20%	\$0
SERVICES – TESTS FOR DIAGNOSTIC			
SERVICES	100%	\$0	\$0

HIGH DEDUCTIBLE PLAN F

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

PARTS A & B

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	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	PLAN	YOU
	PAYS	PAYS	PAY
HOSPITALIZATION*			
Semiprivate room and board,			
general nursing and miscellaneous services and			
supplies First 60 days	All but \$1288	\$1288	\$0
First ou days	All Dut \$1200	(Part A Deductible)	φυ
61st thru 90th day	All but \$322 a day	\$322 a day	\$0
91st day and after	All but \$522 a day	φ022 a uay	ψΟ
•While using 60 lifetime reserve			
days	All but \$644 a day	\$644 a day	\$0
•Once lifetime reserve days are	All but \$044 a day	φu++ a uay	ψΟ
used:			
Additional 365 days	\$0	100% of Medicare	\$0**
-Additional 303 days	ΨΟ	Eligible Expenses	ΨΟ
•Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY	\$	Ψ0	
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		

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	\$0	\$0	\$166
amounts*			(Part B Deductible)
Remainder of Medicare-Approved	O a m a maille : 000/	O a manually : 000/	* 0
amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-Approved			
amounts)	\$0	100%	\$0
BLOOD	φ0	100 /0	ΨΟ
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
SERVICES -			
TESTS FOR DIAGNOSTIC	100%	\$0	\$0
SERVICES	100 %	φυ	φυ

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES •Medically necessary skilled care			
•Durable medical equipment	100%	\$0	\$0
 First \$166 of Medicare Approved amounts* Remainder of Medicare 	\$0	\$0	\$166 (Part B Deductible)
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	PLAN	YOU
	PAYS	PAYS	PAY
Semiprivate room and board,			
general nursing and			
miscellaneous services and			
supplies		¢4000	¢ 0
First 60 days	All but \$1288	\$1288 (Dort A Doductible)	\$0
61 at thru 00th day	All but \$222 a day	(Part A Deductible) \$322 a day	\$0
61st thru 90th day	All but \$322 a day	\$522 a uay	φυ
91st day and after			
•While using 60 lifetime reserve	All but \$611 a day	¢644 o dov	\$0
days	All but \$644 a day	\$644 a day	φυ
•Once lifetime reserve days are used:			
	\$0	100% of Medicare	\$0**
•Additional 365 days	Φ 0	Eligible Expenses	φυ
•Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY	φυ	φυ	
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	T -	T -
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%	\$Ó	\$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		

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.

	MEDICARE	PLAN	YOU
SERVICES	PAYS	PAYS	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* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The 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.	\$166 (Part B Deductible) 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	\$0	\$0	\$166
amounts*			(Part B Deductible)
Remainder of Medicare-Approved	000/	000/	\$ 0
amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN N

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

PARTS A & B

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