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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

Arizona

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 2 BENEFIT PLANS AVAILABLE: A, B, F, HIGH DEDUCTIBLE F, G, Ň 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.

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

z	Basic, including	100% Part B	coinsurance, except	up to \$20	copayment for office	visit, and up to \$50	copayment for ER	Skilled Nursing	Facility Coinsurance	,		Part A Deductible							Foreign Travel		Emergency	:mergency	:mergency	:mergency	:mergency	:mergency	:mergency	:mergency	:mergency	:mergency
Σ	Basic, E	including 1	100% Part B c	coinsurance u	0	>	0	Skilled	Nursing	Facility	Coinsurance		Deductible						Foreign	Travel		lency								
_	Hospitalization	and preventive	care paid at	100%; other	basic benefits	paid at 75%		75% Skilled	Nursing Facility	Coinsurance		75% Part A	Deductible										Out-of-pocket	Out-of-pocket limit \$2480;	Out-of-pocket limit \$2480; paid at 100%	Out-of-pocket limit \$2480; paid at 100% after limit	Out-of-pocket limit \$2480; paid at 100% after limit	Out-of-pocket limit \$2480; paid at 100% after limit	Out-of-pocket limit \$2480; paid at 100% after limit	Out-of-pocket limit \$2480; paid at 100% after limit
¥	Hospitalization	and preventive	care paid at	100%; other	basic benefits	paid at 50%	•	50% Skilled	Nursing	Facility	Coinsurance	50% Part A	Deductible										Out-of-pocket			cket .0; 00%		1		
g	Basic,	including	100% Part B	coinsurance				Skilled	Nursing		Coinsurance	Part A	Deductible			Part B	Excess	(100%)	Foreign	Travel	Fmergency	10.00	(2)						666	666
F/F*	Basic,	including	100% Part B	coinsurance						Facility	Coinsurance	Part A	Deductible	Part B	Deductible	Part B	Excess	(100%)	Foreign	Travel	Emergency	()BI								
٥	Basic,	including	100% Part B	coinsurance				Skilled	Nursing	Facility	Coinsurance	Part A	Deductible						Foreign	Travel	Emergency									
ပ	Basic,	including	100% Part B	coinsurance				Skilled	Nursing	Facility	Coinsurance	Part A	Deductible	Part B	Deductible				Foreign	Travel	Emergency)								
Δ	Basic,	including	100% Part B	coinsurance								Part A	Deductible																	
₹	Basic,	including	100% Part B	coinsurance																										

expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$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 separate foreign travel emergency deductible.

Annual Issue Age Premiums For Use in ZIP Codes: 850

Female Rates

			_	_	_				_								_	_					_	_	_				_			_	_	_		
	Plan N	1,409	1,409	1,409	1,449	1,496	1,535	1,572	1,607	1,638	1,665	1,688	1,706	1,728	1,745	1,758	1,777	1,791	1,806	1,819	1,832	1,844	1,857	1,866	1,884	1,902	1,918	1,933	1,949	1,962	1,975	1,987	1,997	2,009	2,022	2,034
	Plan G	1,647	1,647	1,647	1,692	1,747	1,791	1,836	1,877	1,913	1,944	1,973	1,995	2,015	2,036	2,054	2,073	2,091	2,108	2,125	2,138	2,155	2,168	2,181	2,200	2,219	2,240	2,258	2,276	2,291	2,306	2,319	2,334	2,346	2,360	2,375
Standard	Plan HF	926	926	926	1,004	1,030	1,054	1,076	1,096	1,112	1,126	1,140	1,149	1,157	1,164	1,171	1,175	1,185	1,194	1,204	1,211	1,218	1,225	1,231	1,242	1,252	1,261	1,271	1,281	1,288	1,297	1,301	1,307	1,315	1,321	1,329
Star	Plan F	2,446	2,446	2,446	2,511	2,578	2,637	2,691	2,740	2,778	2,817	2,846	2,871	2,893	2,921	2,943	2,962	2,985	3,010	3,034	3,060	3,086	3,106	3,129	3,155	3,181	3,207	3,230	3,255	3,275	3,293	3,310	3,325	3,343	3,362	3,379
	Plan B	2,081	2,081	2,081	2,139	2,205	2,266	2,322	2,374	2,418	2,458	2,493	2,521	2,547	2,571	2,597	2,620	2,642	2,665	2,685	2,705	2,723	2,741	2,753	2,779	2,805	2,831	2,853	2,876	2,895	2,914	2,932	2,949	2,967	2,983	3,002
	Plan A	1,651	1,651	1,651	1,699	1,751	1,798	1,841	1,882	1,918	1,950	1,977	2,001	2,024	2,042	2,061	2,080	2,095	2,115	2,132	2,147	2,158	2,174	2,187	2,205	2,227	2,246	2,266	2,283	2,297	2,313	2,327	2,340	2,355	2,366	2,381
Issue	Age	92	99	29	89	69	70	71	72	73	74	75	9/	77	78	79	80	81	82	83	84	82	98	87	88	68	90	91	92	93	94	95	96	97	86	99
	N UE	,269	,269	,269	,305	,346	,382	,415	,446	,474	,498	,520	,537	,554	,570	,583	,599	,612	,625	,637	,651	,660	,670	829,	,697	,712	,726	,741	,753	,767	,778	,787	,798	608,	,818	,831
	n G Plan N	1,269	1,269		522 1,305	571 1,346	512 1,382	551 1,415				1,520	796 1,537	312 1,554	332 1,570	` .	365 1,599	380 1,612	396 1,625	1,637	` .	940 1,660	952 1,670	960 1,678		` '	` '	` .	` .	` .	•	•	1,798	114 1,809	125 1,818	1,
	Plan G	1,482	1,482	1,482	1,522	1,571	1,612	1,651	1,689	1,723	1,751	1,774	1,796	1,812	1,832	1,848	1,865	1,880	1,896	1,913	1,925	1,940	1,952	1,960	1,980	1,997	2,015	2,031	2,047	2,061	2,076	2,089	2,100	2,114	2,125	2,136 1,
ferred	Plan HF Plan G			1,482		927 1,571	` '					1,027 1,774	` '	1,040 1,812	1,049 1,832	1,055 1,848	1,062 1,865	1,068 1,880	1,076 1,896	1,084 1,913	1,089 1,925	1,096 1,940	1,103 1,952	1,107 1,960	1,118 1,980	` '	1,135 2,015	1,143 2,031	1,152 2,047	1,159 2,061	1,164 2,076	1,171 2,089	1,176 2,100	1,184 2,114	1,191 2,125	1,194 2,136 1,
Preferred	Plan G	1,482	1,482	1,482	1,522	1,571	1,612	1,651	986 1,689	1,723	1,751	1,774	1,796	1,812	1,832	1,055 1,848	1,865	1,880	1,896	1,913	1,089 1,925	1,096 1,940	1,103 1,952	1,960	1,980	1,997	1,135 2,015	1,143 2,031	1,152 2,047	1,159 2,061	1,164 2,076	1,171 2,089	2,100	2,114	2,125	2,136 1,
Preferred	Plan HF Plan G	878 1,482	878 1,482	2,201 878 1,482	903 1,522	927 1,571	949 1,612	2,422 968 1,651	986 1,689	1,001 1,723	1,014 1,751	1,027 1,774	1,037 1,796	1,040 1,812	1,049 1,832	2,651 1,055 1,848	1,062 1,865	2,688 1,068 1,880	2,710 1,076 1,896	2,729 1,084 1,913	2,753 1,089 1,925	1,096 1,940	1,103 1,952	1,107 1,960	1,118 1,980	1,125 1,997	2,888 1,135 2,015	2,910 1,143 2,031	1,152 2,047	1,159 2,061	1,164 2,076	1,171 2,089	1,176 2,100	1,184 2,114	1,191 2,125	1,194 2,136 1,
Preferred	Plan F Plan HF Plan G	1,875 2,201 878 1,482	2,201 878 1,482	1,875 2,201 878 1,482	2,260 903 1,522	2,318 927 1,571	2,372 949 1,612	2,422 968 1,651	2,466 986 1,689	2,501 1,001 1,723	2,534 1,014 1,751	2,560 1,027 1,774	2,583 1,037 1,796	2,606 1,040 1,812	2,630 1,049 1,832	2,339 2,651 1,055 1,848	2,669 1,062 1,865	2,688 1,068 1,880	2,395 2,710 1,076 1,896	2,729 1,084 1,913	2,433 2,753 1,089 1,925	1 2,452 2,776 1,096 1,940	, 2,467 2,795 1,103 1,952	2,817 1,107 1,960	2,503 2,839 1,118 1,980	2,526 2,864 1,125 1,997	2,547 2,888 1,135 2,015	2,568 2,910 1,143 2,031	2,589 2,927 1,152 2,047	2,606 2,946 1,159 2,061	2,960 1,164 2,076	2,975 1,171 2,089	2,994 1,176 2,100	3,010 1,184 2,114	3,025 1,191 2,125	3,038 1,194 2,136 1,

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

Annual Issue Age Premiums For Use in ZIP Codes: 850

Male Rates

	Plan N	1,621	1,621	1,621	1,666	1,718	1,767	1,809	1,849	1,884	1,916	1,943	1,966	1,983	2,006	2,022	2,041	2,058	2,074	2,093	2,108	2,121	2,134	2,146	2,168	2,186	2,206	2,225	2,241	2,256	2,271	2,284	2,297	2,312	2,325	2,338	
	Plan G	1,893	1,893	1,893	1,946	2,009	2,060	2,112	2,158	2,199	2,235	2,267	2,293	2,317	2,340	2,362	2,382	2,404	2,424	2,442	2,461	2,478	2,493	2,508	2,529	2,553	2,576	2,596	2,615	2,634	2,652	2,668	2,684	2,699	2,713	2,730	0.0833
Standard	Plan HF	1,123	1,123	1,123	1,155	1,184	1,212	1,238	1,260	1,281	1,298	1,313	1,321	1,331	1,337	1,347	1,354	1,363	1,375	1,386	1,392	1,402	1,408	1,415	1,427	1,440	1,449	1,462	1,472	1,482	1,489	1,497	1,503	1,512	1,518	1,527	
Star	Plan F	2,816	2,816	2,816	2,888	2,962	3,032	3,097	3,151	3,196	3,237	3,272	3,300	3,327	3,357	3,386	3,406	3,438	3,461	3,491	3,518	3,548	3,572	3,597	3,629	3,659	3,688	3,717	3,742	3,764	3,784	3,803	3,825	3,843	3,863	3,882	Monthly:
	Plan B	2,392	2,392	2,392	2,460	2,537	2,605	2,669	2,729	2,779	2,827	2,865	2,897	2,929	2,956	2,985	3,014	3,039	3,064	3,088	3,109	3,130	3,151	3,167	3,197	3,227	3,255	3,282	3,307	3,330	3,352	3,372	3,392	3,411	3,432	3,452	Σ
	Plan A	1,900	1,900	1,900	1,955	2,013	2,067	2,119	2,165	2,205	2,242	2,276	2,301	2,325	2,347	2,371	2,391	2,409	2,430	2,452	2,468	2,485	2,501	2,513	2,538	2,560	2,582	2,605	2,624	2,644	2,660	2,676	2,692	2,708	2,725	2,740	0.2650
Issue	Age	9	99	29	89	69	20	71	72	73	74	75	9/	77	78	79	80	81	82	83	84	82	98	87	88	88	6	91	92	93	94	95	96	97	86	66	Quarterly:
	Plan N	1,460	1,460	1,460	1,500	1,549	1,589	1,626	1,664	1,696	1,724	1,747	1,769	1,785	1,806	1,821	1,837	1,852	1,867	1,884	1,895	1,911	1,922	1,931	1,950	1,970	1,984	2,002	2,015	2,030	2,043	2,055	2,067	2,081	2,093	2,106	
	Plan G	1,703	1,703	1,703	1,753	1,808	1,857	1,900	1,942	1,980	2,013	2,040	2,065	2,087	2,108	2,125	2,146	2,163	2,182	2,199	2,214	2,229	2,242	2,254	2,278	2,298	2,318	2,337	2,354	2,370	2,386	2,401	2,414	2,429	2,442	2,457	0.5200
p	Plan HF	13	3	m	m	_	~	.0																													1
rre	Jai	1,013	1,013	1,013	1,038	1,067	1,092	1,116	1,135	1,152	1,169	1,182	1,190	1,199	1,206	1,212	1,219	1,228	1,236	1,244	1,253	1,260	1,268	1,272	1,286	1,297	1,304	1,315	1,323	1,333	1,339	1,348	1,352	1,361	1,369	1,375	
Preferred	Plan F Pla	2,534 1,03	2,534 1,01	_	_	_	2,728 1,093	2,786 1,110	2,838 1,135	7	2,915 1,169	2,944 1,182	2,970 1,190	2,994 1,199	3,024 1,206	3,050 1,212	3,067 1,219	3,090 1,228	3,116 1,236	3,138 1,244	3,167 1,253	3,191 1,260	3,215 1,268	3,238 1,272	_	3,294 1,297	⊣	П	3,366 1,323	3,389 1,333	3,406 1,339	3,425 1,348	3,442 1,352	3,459 1,361	3,478 1,369	3,494 1,375	Annual:
Preferre			_	_	2,597	_	2,728	7	2,838 1	7		_	_			_	_	7				3,191			3,266 1	_	3,318 1	3,344 1	3,366 1	П	_	-		П	П	. 1	Semi-Annual:
Preferre	Plan F	2,534	2,534 1	2,534	2,597	2,669 1	2,728	2,786 1	2,838 1	2,874	2,915	2,944	2,970 1	2,994	2,664 3,024 1	3,050	3,067	3,090	3,116	3,138	2,796 3,167 1	2,817 3,191 1	3,215	3,238	2,878 3,266 1	3,294	2,929 3,318 1	2,953 3,344 1	2,976 3,366 1	3,389 1	3,406 1	3,034 3,425 1	3,442 1	3,459 1	3,478 1	3,494 1	odal Factors: Semi-Annual:

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.

Annual Issue Age Premiums For Use in ZIP Codes: Rest of State

Female Rates

Standard F Plan HF Plan G Plan N	850 1,434	850 1,434	1,434			917 1,559 1,336	936 1,598 1,369		968 1,665 1,426		993 1,717 1,469	1,000 1,736 1,485		1,013 1,772	1,019 1,788	1,023 1,804	1,031 1,820	100 4	1,040 1,835	1,040 1,835 1,048 1,850	1,040 1,835 1,048 1,850 1,054 1,861	1,040 1,835 1,048 1,850 1,054 1,861 1,060 1,875	1,040 1,835 1,048 1,850 1,054 1,861 1,060 1,875 1,066 1,887	1,040 1,835 1,048 1,850 1,054 1,861 1,060 1,875 1,066 1,887 1,072 1,898	1,040 1,835 1,048 1,850 1,054 1,861 1,060 1,875 1,066 1,887 1,072 1,898 1,081 1,915	1,040 1,835 1,048 1,850 1,054 1,861 1,060 1,875 1,066 1,887 1,072 1,898 1,081 1,915 1,089 1,932	1,040 1,835 1,048 1,850 1,054 1,861 1,060 1,875 1,066 1,887 1,072 1,898 1,081 1,915 1,089 1,932 1,098 1,950	1,040 1,835 1,048 1,850 1,054 1,861 1,066 1,887 1,072 1,898 1,081 1,915 1,089 1,932 1,098 1,950 1,106 1,966	1,040 1,835 1,048 1,850 1,054 1,861 1,066 1,887 1,072 1,898 1,081 1,915 1,089 1,932 1,098 1,950 1,106 1,966 1,115 1,981	1,040 1,835 1,048 1,850 1,054 1,861 1,066 1,887 1,072 1,898 1,081 1,915 1,089 1,932 1,098 1,950 1,116 1,966 1,115 1,981	1,040 1,835 1,048 1,850 1,054 1,861 1,066 1,887 1,072 1,898 1,081 1,915 1,089 1,932 1,098 1,950 1,106 1,966 1,115 1,981 1,121 1,994	1,040 1,835 1,048 1,850 1,054 1,861 1,066 1,887 1,072 1,898 1,081 1,915 1,089 1,932 1,098 1,950 1,106 1,966 1,115 1,981 1,121 1,994 1,129 2,007	1,040 1,835 1,048 1,850 1,054 1,861 1,066 1,887 1,072 1,898 1,081 1,915 1,089 1,950 1,106 1,966 1,115 1,981 1,121 1,994 1,129 2,007 1,133 2,018	1,040 1,835 1,048 1,850 1,054 1,861 1,066 1,887 1,072 1,898 1,081 1,915 1,089 1,950 1,106 1,966 1,115 1,981 1,121 1,994 1,129 2,007 1,133 2,018 1,137 2,031	1,040 1,835 1,048 1,850 1,054 1,861 1,066 1,887 1,072 1,898 1,081 1,915 1,089 1,950 1,106 1,966 1,115 1,981 1,121 1,994 1,129 2,007 1,133 2,018 1,137 2,031 1,145 2,042
Sta Plan B Plan F		1,811 2,129		1,862 2,186	1,919 2,244	1,972 2,295	2,021 2,342	2,066 2,385	2,105 2,418	2,139 2,452	2,170 2,477	2,194 2,499	2,217 2,518	2,238 2,543		2,280 2,578																			
Plan A		_	1,437	1,479	1,524	1,565	1,603	1,638	1,669	1,698	1,721	1,742	1,762	1,778	1,794	1,810	1,824		1,841	1,841	1,841 1,856 1,869	1,841 1,856 1,869 1,878	1,841 1,856 1,869 1,878 1,892												
Issue	65	99	29	89	69	70	71	72	73	74	75	9/	77	78	79	80	81		82	83	88 83 84	82 83 85	82 83 84 85 86	82 83 84 85 86 87	82 83 83 85 85 86 87 88 88 88 88 88 88 88 88 88 88 88 88	88 87 88 88 88 88 88 88 88 88 88 88 88 8	83 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	83 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	82 88 88 87 88 89 90 90 92	8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	88 88 88 88 89 89 89 89 89 89 89 89 89 8	82 83 84 85 85 85 86 86 86 86 86 86 86 86 86 86 86 86 86	82 83 84 85 85 85 86 86 86 86 86 86 86 86 86 86 86 86 86	82 83 84 85 85 85 85 85 85 85 85 85 85 85 85 85
z																																			
Plan N	1,105	1,105	1,105	1,136	1,171	1,203	1,231	1,259	1,283	1,304	1,323	1,338	1,353	1,367	1,378	1,392	1,403		1,415	1,415 1,425	1,415 1,425 1,437	1,415 1,425 1,437 1,445	1,415 1,425 1,437 1,445 1,453	1,415 1,425 1,437 1,445 1,453	1,415 1,425 1,437 1,445 1,461 1,461	1,415 1,425 1,445 1,445 1,453 1,461 1,477	1,415 1,425 1,445 1,453 1,461 1,477 1,490 1,502	1,415 1,425 1,437 1,445 1,461 1,477 1,490 1,502	1,415 1,425 1,437 1,445 1,461 1,477 1,502 1,515	1,415 1,425 1,437 1,445 1,461 1,477 1,502 1,515 1,526 1,538	1,415 1,425 1,437 1,445 1,461 1,477 1,502 1,515 1,526 1,538	1,415 1,425 1,437 1,445 1,461 1,477 1,502 1,515 1,526 1,538 1,536	1,415 1,425 1,437 1,445 1,461 1,477 1,502 1,515 1,526 1,538 1,547 1,536	1,415 1,425 1,437 1,445 1,461 1,477 1,502 1,515 1,526 1,538 1,547 1,565	1,415 1,425 1,445 1,445 1,445 1,440 1,502 1,515 1,526 1,538 1,547 1,556 1,565
Plan G Plan		1,290 1,105		1,324 1,136	1,368 1,171	1,403 1,203	1,437 1,231	1,470 1,259	1,499 1,283	1,524 1,304	1,544 1,323	1,563 1,338	1,577 1,353	1,594 1,367		1,623 1,392																			
HF Plan G	1,290	` '	1,290														1,637	1 551	1,00,1	1,651	1,665 1,665 1,675	1,665 1,665 1,675 1,688	1,651 1,665 1,675 1,688 1,699	1,665 1,665 1,675 1,688 1,699 1,706	1,665 1,665 1,675 1,688 1,699 1,706 1,723	1,665 1,665 1,675 1,688 1,699 1,706 1,723 1,738	1,665 1,665 1,675 1,688 1,699 1,706 1,723 1,738	1,665 1,665 1,688 1,689 1,706 1,723 1,738 1,738 1,754	1,665 1,665 1,688 1,699 1,706 1,723 1,738 1,768 1,768	1,665 1,665 1,688 1,699 1,706 1,723 1,738 1,738 1,768	1,665 1,665 1,688 1,699 1,706 1,723 1,738 1,738 1,768 1,781	1,665 1,665 1,688 1,689 1,706 1,723 1,738 1,738 1,768 1,781 1,781 1,781	1,665 1,665 1,688 1,689 1,706 1,738 1,738 1,738 1,781 1,781 1,807 1,807	1,665 1,665 1,688 1,699 1,706 1,738 1,738 1,738 1,781 1,781 1,807 1,807 1,807 1,807	1,665 1,665 1,688 1,699 1,706 1,738 1,738 1,738 1,781 1,781 1,807 1,807 1,807 1,807
	764 1,290	1,290	764 1,290	786 1,324	1,368	1,403	1,437	1,470	1,499	883 1,524	1,544	1,563	1,577	913 1,594	918 1,608	1,623	930 1,637	7,00	936 I,65I	936 1,651 944 1,665	936 1,651 944 1,665 948 1,675	936 1,651 944 1,665 948 1,675 954 1,688	936 1,651 944 1,665 948 1,675 954 1,688 960 1,699	936 1,655 944 1,665 948 1,675 954 1,688 960 1,699	946 1,655 948 1,675 954 1,688 960 1,699 964 1,706 973 1,723	944 1,665 948 1,675 954 1,688 960 1,699 964 1,706 973 1,723	944 1,665 948 1,675 954 1,688 960 1,699 964 1,706 973 1,723 979 1,738	944 1,665 944 1,665 954 1,688 960 1,699 964 1,706 973 1,723 979 1,738 988 1,754	946 1,655 948 1,675 954 1,688 960 1,699 964 1,706 973 1,723 979 1,738 988 1,754 995 1,768 1,003 1,781	946 1,655 948 1,675 954 1,688 960 1,699 964 1,706 973 1,723 979 1,738 988 1,754 995 1,768 1,003 1,781 1,009 1,794	944 1,665 948 1,675 954 1,688 960 1,699 964 1,706 973 1,723 979 1,738 988 1,754 995 1,768 1,003 1,781 1,000 1,794 1,013 1,807	944 1,665 948 1,675 954 1,688 960 1,699 964 1,706 973 1,723 979 1,738 988 1,754 995 1,768 1,003 1,781 1,000 1,794 1,013 1,807 1,013 1,807	944 1,665 948 1,675 954 1,688 960 1,699 964 1,706 973 1,723 979 1,738 988 1,754 995 1,768 1,003 1,781 1,009 1,794 1,013 1,807 1,013 1,807 1,014 1,818	944 1,665 948 1,675 954 1,688 960 1,699 964 1,706 973 1,723 979 1,738 988 1,754 995 1,768 1,003 1,781 1,009 1,794 1,013 1,807 1,013 1,818 1,014 1,818 1,014 1,818	944 1,665 948 1,675 954 1,688 960 1,699 964 1,706 973 1,723 979 1,738 988 1,754 995 1,768 1,003 1,781 1,009 1,794 1,013 1,807 1,013 1,807 1,013 1,818 1,024 1,827 1,030 1,840 1,031 1,837 1,031 1,837
erred Plan HF Plan G	1,916 764 1,290	764 1,290	1,916 764 1,290	1,967 786 1,324	807 1,368	826 1,403	842 1,437	858 1,470	871 1,499	2,205 883 1,524	894 1,544	902 1,563	905 1,577	913 1,594	2,308 918 1,608	924 1,623	2,340 930 1,637	יוט ייטרט סור ר	7,338 930 1,031	2,358 930 1,651 2,375 944 1,665	2,376 930 1,031 2,375 944 1,665 2,396 948 1,675	2,375 944 1,665 2,396 948 1,675 2,416 954 1,688	2,336 936 1,031 2,375 944 1,665 2,396 948 1,675 2,416 954 1,688 2,433 960 1,699	2,336 936 1,031 2,375 944 1,665 2,396 948 1,675 2,416 954 1,688 2,433 960 1,699 2,452 964 1,706	2,336 936 1,031 2,375 944 1,665 2,396 948 1,675 2,416 954 1,688 2,433 960 1,699 2,452 964 1,706 2,471 973 1,723	2,336 936 1,031 2,375 944 1,665 2,396 948 1,675 2,416 954 1,688 2,433 960 1,699 2,452 964 1,706 2,471 973 1,723 2,493 979 1,738	2,336 936 1,031 2,375 944 1,665 2,396 948 1,675 2,416 954 1,688 2,433 960 1,699 2,452 964 1,706 2,471 973 1,723 2,493 979 1,738 2,514 988 1,754	2,336 936 1,031 2,375 944 1,665 2,396 948 1,675 2,416 954 1,688 2,433 960 1,699 2,452 964 1,706 2,471 973 1,723 2,493 979 1,738 2,514 988 1,754 2,532 995 1,768	2,336 936 1,031 2,375 944 1,665 2,396 948 1,675 2,416 954 1,688 2,433 960 1,699 2,452 964 1,706 2,471 973 1,723 2,493 979 1,738 2,514 988 1,754 2,532 995 1,768 2,534 1,003 1,781	2,336 936 1,031 2,375 944 1,665 2,396 948 1,675 2,416 954 1,688 2,433 960 1,699 2,452 964 1,706 2,471 973 1,723 2,493 979 1,738 2,514 988 1,754 2,532 995 1,768 2,547 1,003 1,781 2,547 1,003 1,781 2,554 1,009 1,794	2,336 936 1,031 2,375 944 1,665 2,396 948 1,675 2,416 954 1,688 2,433 960 1,699 2,471 973 1,723 2,493 979 1,738 2,514 988 1,754 2,532 995 1,768 2,534 1,003 1,781 2,547 1,003 1,794 2,554 1,009 1,794 2,577 1,013 1,807	2,336 936 1,031 2,375 944 1,665 2,396 948 1,675 2,416 954 1,688 2,433 960 1,699 2,471 973 1,723 2,493 979 1,738 2,514 988 1,754 2,532 995 1,788 2,547 1,003 1,794 2,554 1,003 1,794 2,577 1,013 1,807 2,590 1,019 1,818	2,336 936 1,031 2,375 944 1,665 2,416 954 1,665 2,416 954 1,688 2,433 960 1,699 2,471 973 1,723 2,493 979 1,738 2,514 988 1,754 2,532 995 1,768 2,547 1,003 1,794 2,554 1,009 1,794 2,557 1,013 1,807 2,590 1,019 1,818 2,606 1,024 1,827	2,336 936 1,031 2,375 944 1,665 2,416 954 1,665 2,433 960 1,689 2,432 964 1,706 2,471 973 1,733 2,493 979 1,734 2,514 988 1,754 2,532 995 1,768 2,547 1,003 1,794 2,554 1,009 1,794 2,557 1,013 1,807 2,500 1,019 1,818 2,606 1,024 1,827 2,620 1,030 1,840	2,336 936 1,031 2,375 944 1,665 2,416 954 1,665 2,433 960 1,699 2,452 964 1,706 2,471 973 1,733 2,493 979 1,734 2,514 988 1,754 2,532 995 1,768 2,547 1,003 1,794 2,554 1,009 1,794 2,557 1,013 1,807 2,500 1,019 1,818 2,606 1,024 1,827 2,620 1,030 1,840 2,633 1,037 1,850 2,633 1,037 1,850
Preferred Plan F Plan G	1,632 1,916 764 1,290	1,916 764 1,290	1,632 1,916 764 1,290	1,676 1,967 786 1,324	2,017 807 1,368	1,776 2,064 826 1,403	2,108 842 1,437	2,146 858 1,470	2,177 871 1,499	1,927 2,205 883 1,524	2,228 894 1,544	2,248 902 1,563	1,995 2,268 905 1,577	2,016 2,289 913 1,594	2,036 2,308 918 1,608	2,323 924 1,623	2,069 2,340 930 1,637	1.655 2.085 2.358 936 1.651 1.415	1,000 2,000 1,001	2,103 2,375 944 1,665	2,103 2,375 944 1,665 2,118 2,396 948 1,675	2,103 2,375 944 1,665 2,118 2,396 948 1,675 2,134 2,416 954 1,688	2,103 2,375 944 1,665 2,118 2,396 948 1,675 2,134 2,416 954 1,688 2,147 2,433 960 1,699	2,103 2,375 944 1,665 2,118 2,396 948 1,675 2,134 2,416 954 1,688 2,147 2,433 960 1,699 2,158 2,452 964 1,706	2,103 2,375 944 1,665 2,118 2,396 948 1,675 2,134 2,416 954 1,688 2,147 2,433 960 1,699 2,158 2,452 964 1,706 2,179 2,471 973 1,723	2,103 2,375 944 1,665 2,118 2,396 948 1,675 2,134 2,416 954 1,688 2,147 2,433 960 1,699 2,158 2,179 2,471 973 1,723 2,199 2,493 979 1,738	2,103 2,375 944 1,665 2,118 2,396 948 1,675 2,134 2,416 954 1,688 2,147 2,433 960 1,699 2,158 2,479 2,493 973 1,723 2,199 2,493 979 1,734 2,217 2,514 988 1,754	2,103 2,375 944 1,665 2,118 2,396 948 1,675 2,134 2,416 954 1,688 2,134 2,433 960 1,699 2,158 2,452 964 1,706 2,179 2,471 973 1,723 2,199 2,493 979 1,738 2,217 2,514 988 1,754 2,235 2,532 995 1,768	2,732 2,735 2,113 2,335 944 1,665 2,113 2,416 954 1,675 2,134 2,416 954 1,675 2,147 2,433 960 1,639 2,158 2,452 964 1,706 2,179 2,471 973 1,723 2,199 2,493 979 1,738 2,217 2,514 988 1,754 2,235 2,532 995 1,768 2,253 2,547 1,003 1,781	2,732 2,735 2,735 2,735 2,735 2,744 1,665 2,118 2,396 948 1,675 2,134 2,416 954 1,668 2,147 2,443 960 1,699 2,158 2,452 964 1,706 2,178 2,179 2,471 973 1,723 2,178 2,173 2,173 2,173 2,178 2,178 2,178 2,178 2,178 2,233 2,547 1,003 1,781 2,233 2,547 1,003 1,781 2,253 2,547 1,003 1,781 2,258 2,564 1,003 1,794 2,794 <td>2,732 2,735 2,735 2,735 2,735 2,744 1,665 2,118 2,396 948 1,675 2,134 2,416 954 1,688 2,147 2,443 960 1,699 2,148 2,443 964 1,706 2,178 2,179 2,471 973 1,723 2,173 2,173 2,173 2,173 2,173 2,173 2,174 2,174 3,178 2,174 2,174 2,174 2,174 2,174 3,174 3,174 2,235 2,532 995 1,768 2,253 2,547 1,003 1,794 2,253 2,547 1,003 1,794 2,254 2,547 1,003 1,794 2,284 2,547 1,013 1,781 2,281 2,577 1,013 1,807 1,794</td> <td>2,732 2,732 2,732 2,113 2,346 944 1,665 2,113 2,416 954 1,665 2,134 2,436 954 1,668 2,147 2,433 960 1,699 2,158 2,452 964 1,706 2,179 2,471 973 1,723 2,199 2,493 979 1,738 2,217 2,514 988 1,754 2,235 2,532 995 1,768 2,235 2,547 1,003 1,781 2,253 2,547 1,003 1,794 2,281 2,577 1,013 1,807 2,281 2,577 1,013 1,818 2,296 2,590 1,019 1,818</td> <td>2,732 2,735 2,735 2,735 2,735 2,735 2,744 1,665 2,118 2,346 948 1,675 2,134 2,416 954 1,688 2,147 2,443 960 1,689 2,158 2,452 964 1,706 2,178 2,173 2,173 2,173 2,173 2,173 2,173 2,173 2,173 2,178<!--</td--><td>2,323 2,325 2,426 2,465 2,118 2,346 948 1,675 2,134 2,416 954 1,668 2,134 2,433 960 1,699 2,178 2,473 964 1,706 2,179 2,471 973 1,723 2,199 2,493 979 1,738 2,217 2,514 988 1,754 2,235 2,537 1,003 1,781 2,253 2,547 1,003 1,794 2,253 2,547 1,003 1,794 2,281 2,577 1,013 1,807 2,296 2,590 1,013 1,818 2,311 2,606 1,024 1,827 2,324 2,620 1,030 1,840</td><td>2,732 2,732 2,732 2,113 2,346 948 1,665 2,113 2,416 954 1,665 2,134 2,443 960 1,699 2,178 2,473 964 1,706 2,179 2,471 973 1,723 2,199 2,493 979 1,738 2,217 2,514 988 1,754 2,235 2,532 995 1,768 2,235 2,547 1,003 1,781 2,253 2,547 1,003 1,784 2,281 2,547 1,013 1,807 2,281 2,577 1,013 1,818 2,296 2,590 1,019 1,818 2,311 2,606 1,024 1,827 2,334 2,633 1,037 1,850 2,337 2,633 1,037 1,850</td></td>	2,732 2,735 2,735 2,735 2,735 2,744 1,665 2,118 2,396 948 1,675 2,134 2,416 954 1,688 2,147 2,443 960 1,699 2,148 2,443 964 1,706 2,178 2,179 2,471 973 1,723 2,173 2,173 2,173 2,173 2,173 2,173 2,174 2,174 3,178 2,174 2,174 2,174 2,174 2,174 3,174 3,174 2,235 2,532 995 1,768 2,253 2,547 1,003 1,794 2,253 2,547 1,003 1,794 2,254 2,547 1,003 1,794 2,284 2,547 1,013 1,781 2,281 2,577 1,013 1,807 1,794	2,732 2,732 2,732 2,113 2,346 944 1,665 2,113 2,416 954 1,665 2,134 2,436 954 1,668 2,147 2,433 960 1,699 2,158 2,452 964 1,706 2,179 2,471 973 1,723 2,199 2,493 979 1,738 2,217 2,514 988 1,754 2,235 2,532 995 1,768 2,235 2,547 1,003 1,781 2,253 2,547 1,003 1,794 2,281 2,577 1,013 1,807 2,281 2,577 1,013 1,818 2,296 2,590 1,019 1,818	2,732 2,735 2,735 2,735 2,735 2,735 2,744 1,665 2,118 2,346 948 1,675 2,134 2,416 954 1,688 2,147 2,443 960 1,689 2,158 2,452 964 1,706 2,178 2,173 2,173 2,173 2,173 2,173 2,173 2,173 2,173 2,178 </td <td>2,323 2,325 2,426 2,465 2,118 2,346 948 1,675 2,134 2,416 954 1,668 2,134 2,433 960 1,699 2,178 2,473 964 1,706 2,179 2,471 973 1,723 2,199 2,493 979 1,738 2,217 2,514 988 1,754 2,235 2,537 1,003 1,781 2,253 2,547 1,003 1,794 2,253 2,547 1,003 1,794 2,281 2,577 1,013 1,807 2,296 2,590 1,013 1,818 2,311 2,606 1,024 1,827 2,324 2,620 1,030 1,840</td> <td>2,732 2,732 2,732 2,113 2,346 948 1,665 2,113 2,416 954 1,665 2,134 2,443 960 1,699 2,178 2,473 964 1,706 2,179 2,471 973 1,723 2,199 2,493 979 1,738 2,217 2,514 988 1,754 2,235 2,532 995 1,768 2,235 2,547 1,003 1,781 2,253 2,547 1,003 1,784 2,281 2,547 1,013 1,807 2,281 2,577 1,013 1,818 2,296 2,590 1,019 1,818 2,311 2,606 1,024 1,827 2,334 2,633 1,037 1,850 2,337 2,633 1,037 1,850</td>	2,323 2,325 2,426 2,465 2,118 2,346 948 1,675 2,134 2,416 954 1,668 2,134 2,433 960 1,699 2,178 2,473 964 1,706 2,179 2,471 973 1,723 2,199 2,493 979 1,738 2,217 2,514 988 1,754 2,235 2,537 1,003 1,781 2,253 2,547 1,003 1,794 2,253 2,547 1,003 1,794 2,281 2,577 1,013 1,807 2,296 2,590 1,013 1,818 2,311 2,606 1,024 1,827 2,324 2,620 1,030 1,840	2,732 2,732 2,732 2,113 2,346 948 1,665 2,113 2,416 954 1,665 2,134 2,443 960 1,699 2,178 2,473 964 1,706 2,179 2,471 973 1,723 2,199 2,493 979 1,738 2,217 2,514 988 1,754 2,235 2,532 995 1,768 2,235 2,547 1,003 1,781 2,253 2,547 1,003 1,784 2,281 2,547 1,013 1,807 2,281 2,577 1,013 1,818 2,296 2,590 1,019 1,818 2,311 2,606 1,024 1,827 2,334 2,633 1,037 1,850 2,337 2,633 1,037 1,850

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.

Annual Issue Age Premiums For Use in ZIP Codes: Rest of State

Male Rates

Issue			Prefe	Preferred			Issue			Star	Standard		
Age	Plan A	Plan B	Plan F	Plan F Plan HF	Plan G	Plan N	Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
92	1,488	1,873	2,205	882	1,482	1,271	92	1,653	2,082	2,451	826	1,648	1,411
99	1,488	1,873	2,205	882	1,482	1,271	99	1,653	2,082	2,451	826	1,648	1,411
29	1,488	1,873	2,205	882	1,482	1,271	29	1,653	2,082	2,451	826	1,648	1,411
89	1,529	1,928	2,261	903	1,526	1,306	89	1,701	2,141	2,514	1,005	1,694	1,450
69	1,577	1,988	2,323	929	1,574	1,348	69	1,752	2,208	2,578	1,030	1,748	1,496
70	1,618	2,040	2,374	950	1,616	1,383	70	1,799	2,267	2,639	1,055	1,793	1,538
71	1,660	2,091	2,425	971	1,653	1,416	71	1,844	2,323	2,696	1,077	1,839	1,575
72	1,697	2,139	2,470	886	1,690	1,449	72	1,885	2,375	2,743	1,097	1,878	1,609
73	1,729	2,178	2,501	1,003	1,723	1,476	73	1,919	2,419	2,781	1,115	1,914	1,639
74	1,756	2,214	2,537	1,017	1,752	1,500	74	1,951	2,461	2,817	1,130	1,945	1,668
75	1,783	2,245	2,562	1,028	1,776	1,521	75	1,981	2,494	2,848	1,143	1,973	1,691
9/	1,801	2,269	2,585	1,036	1,797	1,540	9/	2,003	2,521	2,873	1,150	1,996	1,711
77	1,819	2,295	2,606	1,043	1,816	1,554	77	2,024	2,549	2,896	1,158	2,016	1,726
78	1,841	2,319	2,632	1,050	1,835	1,572	78	2,043	2,573	2,922	1,164	2,037	1,746
79	1,857	2,339	2,655	1,055	1,850	1,585	79	2,063	2,598	2,947	1,172	2,056	1,760
80	1,873	2,360	2,670	1,061	1,868	1,599	80	2,081	2,624	2,965	1,179	2,074	1,777
81	1,888	2,379	2,689	1,069	1,883	1,612	81	2,097	2,645	2,992	1,186	2,092	1,792
82	1,904	2,400	2,712	1,075	1,899	1,625	82	2,115	2,667	3,013	1,197	2,109	1,805
83	1,919	2,419	2,732	1,083	1,914	1,639	83	2,134	2,687	3,038	1,206	2,125	1,822
84	1,933	2,434	2,756	1,090	1,927	1,650	84	2,148	2,706	3,062	1,212	2,142	1,835
82	1,947	2,452	2,778	1,097	1,940	1,663	82	2,163	2,724	3,088	1,220	2,156	1,846
98	1,958	2,467	2,798	1,104	1,951	1,673	98	2,177	2,743	3,109	1,226	2,170	1,857
87	1,968	2,481	2,818	1,107	1,962	1,681	87	2,187	2,756	3,131	1,231	2,183	1,868
88	1,988	2,505	2,843	1,120	1,982	1,698	88	2,209	2,782	3,158	1,242	2,201	1,887
68	2,005	2,530	2,867	1,129	2,000	1,715	88	2,228	2,809	3,185	1,253	2,222	1,903
96	2,025	2,549	2,888	1,135	2,017	1,727	8	2,248	2,833	3,210	1,261	2,242	1,920
91	2,041	2,570	2,910	1,145	2,034	1,743	91	2,267	2,857	3,235	1,273	2,260	1,936
95	2,056	2,591	2,930	1,152	2,049	1,754	95	2,284	2,878	3,257	1,281	2,276	1,951
93	2,070	2,610	2,950	1,160	2,062	1,767	93	2,301	2,898	3,276	1,290	2,293	1,964
94	2,083	2,626	2,965	1,166	2,076	1,778	94	2,315	2,918	3,294	1,296	2,309	1,977
92	2,095	2,640	2,981	1,173	2,090	1,789	92	2,329	2,935	3,310	1,303	2,322	1,988
96	2,109	2,656	2,996	1,177	2,101	1,799	96	2,343	2,953	3,329	1,308	2,336	1,999
97	2,119	2,671	3,011	1,184	2,114	1,811	97	2,357	2,969	3,345	1,316	2,349	2,013
86	2,134	2,686	3,027	1,192	2,125	1,822	86	2,372	2,987	3,362	1,322	2,361	2,024
99	2,147	2,703	3,041	1,197	2,139	1,833	66	2,385	3,004	3,378	1,329	2,376	2,035
lodal Factors:	tors:	Semi-,	Semi-Annual:		0.5200		Quarterly:	0.2650	2	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 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 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, 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*	FAIS	FAIS	FAI
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	\$0**
		Eligible Expenses	
Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY			
CARE*			
You must meet Medicare's			
requirements, including having			
been in a hospital for at least 3			
days and entered a Medicare-			
Approved facility within 30 days after leaving the hospital			
First 20 days	All approved 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	43		7 00010
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's	All but very limited	Medicare	\$0
requirements, including a doctor's	copayment/	copayment/	
certification of terminal illness.	coinsurance for	coinsurance	
	outpatient drugs and		
	inpatient respite care		

^{**}NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 -	1 7 10	IAIO	IAI
IN OR OUT OF THE HOSPITAL			
AND OUTPATIENT HOSPITAL			
TREATMENT, such as physician's			
services, inpatient and outpatient			
medical and surgical services and			
supplies, physical and speech			
therapy, diagnostic test, durable			
medical equipment			
First \$166 of Medicare-Approved	\$0	\$0	\$166
amounts*			(Part B Deductible)
Remainder of Medicare-Approved			
amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges	_		
(Above Medicare-Approved			
amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$166 of Medicare-Approved	\$0	\$0	\$166
amounts*			(Part B Deductible)
Remainder of Medicare-Approved			
amounts	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES -			
TESTS FOR DIAGNOSTIC			
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	\$0
		(Part A Deductible)	
61st thru 90th day	All but \$322 a day	\$322 a day	\$0
91st day and after			
While using 60 lifetime reserve			
days	All but \$644 a day	\$644 a day	\$0
 Once lifetime reserve days are 			
used:			
 Additional 365 days 	\$0	100% of Medicare	\$0**
		Eligible Expenses	
 ●Beyond the Additional 365 days 	\$0	\$0	All costs
SKILLED NURSING FACILITY			
CARE*			
You must meet Medicare's			
requirements, including having			
been in a hospital for at least 3			
days and entered a Medicare-			
Approved facility within 30 days			
after leaving the hospital			
First 20 days	All approved	\$0	\$0
	amounts		
21st thru 100th day	All but \$161 a day	\$0	Up to \$161 a day
101st day and after	\$0	\$0	All costs
BLOOD	00	0 -:-1-	ФО.
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE	All land many limpitard	Madiagna	.
You must meet Medicare's	All but very limited	Medicare	\$0
requirements, including a doctor's	copayment/	copayment/	
certification of terminal illness.	coinsurance for	coinsurance	
	outpatient drugs		
	and inpatient		
	respite care		

^{**}NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

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

* Once you have been billed \$166 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES -	_		
IN OR OUT OF THE HOSPITAL			
AND OUTPATIENT HOSPITAL			
TREATMENT, such as physician's			
services, inpatient and outpatient			
medical and surgical services and			
supplies, physical and speech			
therapy, diagnostic test, durable			
medical equipment			
First \$166 of Medicare-Approved	\$0	\$0	\$166
amounts*			(Part B Deductible)
Remainder of Medicare-Approved			
amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges			
(Above Medicare-Approved			
amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$166 of Medicare-Approved	\$0	\$0	\$166
amounts*			(Part B Deductible)
Remainder of Medicare-Approved	000/	000/	
amounts	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES -			
	1	1	
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	100%	\$0	\$0
 services and medical supplies Durable medical equipment First \$166 of Medicare Approved amounts* 	\$0	\$0	\$166 (Part B Deductible)
Remainder of Medicare Approved amounts	80%	20%	\$0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board,			
general nursing and			
miscellaneous services and			
supplies			
First 60 days	All but \$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:			
Additional 365 days	\$0	100% of Medicare	\$0**
		Eligible Expenses	
Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY			
CARE*			
You must meet Medicare's			
requirements, including having			
been in a hospital for at least 3			
days and entered a Medicare-			
Approved facility within 30 days			
after leaving the hospital			
First 20 days	All approved	\$0	\$0
04 - 1 (b - 400) b - 1 -	amounts	11-1-0404 - 1-	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 mints	C O	2 mints	CO
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE You must meet Medicare's	All but york limited	Medicare	\$0
	All but very limited		φυ
requirements, including a doctor's certification of terminal illness.	copayment/ coinsurance for	copayment/ coinsurance	
Certification of terminal limess.	outpatient drugs	Comsulance	
	and inpatient		
	respite care		
	respite care		

^{**}NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

*Once you have been billed \$166 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES -	_	_	
IN OR OUT OF THE HOSPITAL			
AND OUTPATIENT HOSPITAL			
TREATMENT, such as physician's			
services, inpatient and outpatient			
medical and surgical services and			
supplies, physical and speech			
therapy, diagnostic test, durable			
medical equipment			
First \$166 of Medicare-Approved	\$0	\$166	\$0
amounts*		(Part B Deductible)	
Remainder of Medicare-Approved			
amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges			
(Above Medicare-Approved			
amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$166 of Medicare-Approved	\$0	\$166	\$0
amounts*		(Part B Deductible)	
Remainder of Medicare-Approved		2004	
amounts	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES -			
TESTS FOR DIAGNOSTIC	4000/		
SERVICES	100%	\$0	\$0

PARTS A & B

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

PLAN F OTHER BENEFITS – NOT COVERED BY MEDICARE

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

High Deductible F

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

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

***This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$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 \$2180	IN ADDITION TO \$2180
SERVICES	MEDICARE PAYS	DEDUCTIBLE*** PLAN PAYS	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	All but very limited	Medicare	\$0
requirements, including a doctor's	copayment/	copayment/	
certification of terminal illness.	coinsurance for	coinsurance	
	outpatient drugs		
	and inpatient		
	respite care		

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed \$166 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

***This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$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.

	AETED VOLLDAV	IN ADDITION TO
		\$2180
MEDICARE	DEDUCTIBLE***	DEDUCTIBLE***
PAYS	PLAN PAYS	YOU PAY
\$0	'	\$0
	(Part B Deductible)	
Generally 80%	Generally 20%	\$0
C O	4000/	C O
\$0	100%	\$0
60	All costs	\$0
		\$0
φυ	'	φυ
	(i ait b beductible)	
80%	20%	\$0
0070	2070	ΨΟ
100%	\$0	\$0
	\$0 Generally 80% \$0 \$0 80 \$0	\$0 \$166 (Part B Deductible) Generally 80% Generally 20% \$0 100% \$0 All costs \$166 (Part B Deductible) \$0 PLAN PAYS

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	20% and amounts
		maximum benefit of	over the \$50,000
		\$50,000	lifetime maximum

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board,			
general nursing and			
miscellaneous services and			
supplies			
First 60 days	All but \$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:			
 Additional 365 days 	\$0	100% of Medicare	\$0**
		Eligible Expenses	
 ◆Beyond the Additional 365 days 	\$0	\$0	All costs
SKILLED NURSING FACILITY			
CARE*			
You must meet Medicare's			
requirements, including having			
been in a hospital for at least 3			
days and entered a Medicare-			
Approved facility within 30 days			
after leaving the hospital			
First 20 days	All approved	\$0	\$0
04 4 4 4 4004 1	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	# 0	0 : 1	
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE	All book come limaite al	Madiagra	ro.
You must meet Medicare's	All but very limited	Medicare	\$0
requirements, including a doctor's	copayment/ coinsurance for	copayment/	
certification of terminal illness services		coinsurance	
SCIVICES	outpatient drugs		
	and inpatient respite care		
	respite care		

^{**}NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

*Once you have been billed \$166 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES -			
IN OR OUT OF THE HOSPITAL			
AND OUTPATIENT HOSPITAL			
TREATMENT, such as physician's			
services, inpatient and outpatient			
medical and surgical services and			
supplies, physical and speech			
therapy, diagnostic test, durable			
medical equipment			
First \$166 of Medicare-Approved	\$0	\$0	\$166
amounts*			(Part B Deductible)
Remainder of Medicare-Approved			
amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges			
(Above Medicare-Approved			
amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$166 of Medicare-Approved	\$0	\$0	\$166
amounts*			(Part B Deductible)
Remainder of Medicare-Approved			
amounts	80%	20%	\$0
CLINICAL LABORATORY			
SERVICES -			
TESTS FOR DIAGNOSTIC			
SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE -			
MEDICARE APPROVED			
SERVICES			
 Medically necessary skilled care 			
services and medical supplies	100%	\$0	\$0
Durable medical equipment			
•First \$166 of Medicare	\$0	\$0	\$166
Approved amounts*			(Part B Deductible)
•Remainder of Medicare			
Approved amounts	80%	20%	\$0

PLAN G

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL -			
NOT COVERED BY MEDICARE			
Medically necessary emergency			
care services beginning during the			
first 60 days of each trip outside			
the USA			
First \$250 each calendar year	\$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 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	\$0
		(Part A Deductible)	
61st thru 90th day	All but \$322 a day	\$322 a day	\$0
91st day and after			
 While using 60 lifetime reserve 			
days	All but \$644 a day	\$644 a day	\$0
Once lifetime reserve days are			
used:			
Additional 365 days	\$0	100% of Medicare	\$0**
		Eligible Expenses	
 ●Beyond the Additional 365 days 	\$0	\$0	All costs
SKILLED NURSING FACILITY			
CARE*			
You must meet Medicare's			
requirements, including having			
been in a hospital for at least 3			
days and entered a Medicare-			
Approved facility within 30 days			
after leaving the hospital			
First 20 days	All approved	\$0	\$0
	amounts		
21st thru 100th day	All but \$161 a day	Up to \$161 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's	All but very limited	Medicare	\$0
requirements, including a doctor's	copayment/	co-payment/	
certification of terminal illness	coinsurance for	coinsurance	
services	outpatient drugs		
	and inpatient		
	respite care		

^{**}NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

*Once you have been billed \$166 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE	PLAN	YOU
	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 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.	\$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 Next \$166 of Medicare-Approved amounts*	\$0 \$0	All costs \$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	\$0	\$0	\$166
Approved amounts*			(Part B Deductible)
•Remainder of Medicare			
Approved amounts	80%	20%	\$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

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