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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**

NEW MEXICO

ACIMS01056NM

Rates Effective: 10/2016 A

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

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

Basic Benefits:
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-Approved expenses) or, 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.
Hospice: Part A coinsurance

A	B	C	D	F/F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $4960; paid at 100% after limit reached	Out-of-pocket limit $2480; paid at 100% after limit reached		

*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 expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

American Continental Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: 870-872

Female Rates

Rates Effective 10/01/2016

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,158	1,460	1,697	667	1,236	1,036
66	1,158	1,460	1,697	667	1,236	1,036
67	1,158	1,460	1,697	667	1,236	1,036
68	1,208	1,521	1,766	694	1,287	1,079
69	1,261	1,589	1,834	722	1,344	1,128
70	1,311	1,655	1,903	749	1,397	1,173
71	1,362	1,715	1,968	774	1,451	1,217
72	1,410	1,776	2,030	799	1,501	1,261
73	1,454	1,833	2,085	821	1,549	1,300
74	1,497	1,885	2,138	842	1,593	1,337
75	1,533	1,932	2,188	860	1,634	1,372
76	1,569	1,976	2,231	879	1,672	1,403
77	1,603	2,017	2,270	893	1,708	1,435
78	1,632	2,057	2,304	907	1,742	1,462
79	1,663	2,094	2,336	920	1,772	1,486
80	1,688	2,127	2,366	931	1,800	1,511
81	1,712	2,156	2,396	942	1,826	1,531
82	1,734	2,187	2,427	955	1,849	1,552
83	1,758	2,215	2,455	967	1,873	1,572
84	1,780	2,242	2,483	978	1,897	1,593
85	1,800	2,270	2,513	989	1,919	1,610
86	1,821	2,293	2,537	998	1,941	1,627
87	1,839	2,318	2,563	1,008	1,962	1,645
88	1,857	2,342	2,587	1,018	1,982	1,663
89	1,876	2,364	2,607	1,025	2,000	1,678
90	1,891	2,384	2,631	1,035	2,017	1,694
91	1,908	2,405	2,651	1,043	2,034	1,706
92	1,922	2,424	2,669	1,049	2,049	1,719
93	1,934	2,440	2,685	1,057	2,064	1,732
94	1,949	2,455	2,699	1,061	2,079	1,742
95	1,960	2,468	2,713	1,067	2,091	1,754
96	1,973	2,483	2,727	1,074	2,101	1,764
97	1,984	2,498	2,741	1,078	2,114	1,773
98	1,994	2,514	2,756	1,085	2,126	1,784
99	2,007	2,529	2,768	1,089	2,138	1,795

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,287	1,624	1,885	741	1,373	1,151
66	1,287	1,624	1,885	741	1,373	1,151
67	1,287	1,624	1,885	741	1,373	1,151
68	1,340	1,690	1,962	772	1,430	1,201
69	1,402	1,765	2,041	803	1,495	1,254
70	1,456	1,835	2,114	830	1,554	1,303
71	1,512	1,907	2,188	860	1,613	1,352
72	1,566	1,973	2,256	886	1,669	1,400
73	1,614	2,035	2,317	912	1,721	1,444
74	1,663	2,094	2,377	936	1,772	1,487
75	1,703	2,147	2,431	956	1,815	1,524
76	1,741	2,196	2,477	975	1,858	1,559
77	1,780	2,243	2,520	993	1,897	1,593
78	1,815	2,286	2,560	1,007	1,935	1,623
79	1,847	2,328	2,594	1,020	1,967	1,650
80	1,876	2,364	2,629	1,034	2,000	1,678
81	1,903	2,398	2,661	1,047	2,028	1,702
82	1,929	2,429	2,696	1,061	2,055	1,725
83	1,953	2,461	2,728	1,074	2,082	1,747
84	1,977	2,492	2,761	1,086	2,109	1,768
85	2,000	2,520	2,791	1,098	2,133	1,789
86	2,024	2,550	2,819	1,109	2,157	1,811
87	2,043	2,575	2,846	1,119	2,179	1,829
88	2,065	2,602	2,874	1,131	2,202	1,847
89	2,084	2,626	2,899	1,140	2,221	1,864
90	2,105	2,651	2,922	1,149	2,242	1,881
91	2,120	2,670	2,944	1,158	2,261	1,894
92	2,137	2,691	2,966	1,169	2,277	1,911
93	2,151	2,711	2,983	1,173	2,293	1,923
94	2,165	2,728	3,000	1,181	2,309	1,937
95	2,178	2,746	3,014	1,186	2,321	1,949
96	2,190	2,761	3,031	1,190	2,334	1,959
97	2,205	2,777	3,046	1,199	2,348	1,969
98	2,216	2,791	3,062	1,204	2,363	1,982
99	2,231	2,810	3,077	1,210	2,378	1,995

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

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

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

American Continental Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: 870-872

Male Rates

Rates Effective 10/01/2016

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,333	1,679	1,951	769	1,420	1,192
66	1,333	1,679	1,951	769	1,420	1,192
67	1,333	1,679	1,951	769	1,420	1,192
68	1,388	1,751	2,030	799	1,479	1,242
69	1,451	1,829	2,111	830	1,547	1,299
70	1,509	1,901	2,189	861	1,608	1,349
71	1,567	1,973	2,264	893	1,669	1,400
72	1,622	2,042	2,336	920	1,727	1,449
73	1,672	2,106	2,398	942	1,781	1,495
74	1,720	2,166	2,461	969	1,834	1,538
75	1,764	2,220	2,516	990	1,880	1,577
76	1,803	2,273	2,563	1,008	1,923	1,612
77	1,841	2,320	2,607	1,025	1,964	1,648
78	1,878	2,366	2,651	1,043	2,001	1,681
79	1,910	2,407	2,687	1,057	2,036	1,709
80	1,943	2,445	2,720	1,071	2,068	1,737
81	1,968	2,481	2,756	1,085	2,100	1,761
82	1,997	2,515	2,791	1,098	2,127	1,785
83	2,023	2,549	2,824	1,112	2,155	1,806
84	2,045	2,576	2,857	1,125	2,182	1,830
85	2,071	2,607	2,889	1,135	2,206	1,853
86	2,094	2,637	2,917	1,148	2,232	1,872
87	2,115	2,667	2,947	1,159	2,255	1,891
88	2,138	2,692	2,974	1,170	2,278	1,912
89	2,156	2,719	3,001	1,181	2,299	1,930
90	2,177	2,742	3,024	1,188	2,320	1,947
91	2,195	2,764	3,047	1,199	2,339	1,963
92	2,210	2,785	3,067	1,207	2,357	1,977
93	2,229	2,807	3,088	1,214	2,372	1,991
94	2,239	2,824	3,105	1,223	2,389	2,004
95	2,252	2,840	3,120	1,227	2,403	2,017
96	2,266	2,857	3,135	1,233	2,416	2,027
97	2,280	2,872	3,151	1,240	2,431	2,040
98	2,293	2,890	3,168	1,247	2,445	2,052
99	2,307	2,908	3,184	1,252	2,461	2,064

Modal Factors: Semi-Annual: 0.5200

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,480	1,865	2,166	853	1,579	1,325
66	1,480	1,865	2,166	853	1,579	1,325
67	1,480	1,865	2,166	853	1,579	1,325
68	1,542	1,943	2,257	886	1,644	1,379
69	1,610	2,030	2,344	923	1,719	1,442
70	1,677	2,112	2,431	956	1,788	1,500
71	1,740	2,192	2,516	990	1,855	1,556
72	1,800	2,270	2,594	1,020	1,918	1,610
73	1,857	2,340	2,664	1,048	1,980	1,661
74	1,910	2,407	2,733	1,075	2,036	1,709
75	1,958	2,467	2,795	1,101	2,087	1,753
76	2,004	2,524	2,849	1,121	2,137	1,793
77	2,046	2,581	2,899	1,140	2,182	1,830
78	2,085	2,629	2,942	1,157	2,223	1,866
79	2,122	2,676	2,984	1,173	2,262	1,898
80	2,156	2,717	3,022	1,188	2,299	1,929
81	2,188	2,758	3,062	1,204	2,333	1,957
82	2,217	2,793	3,101	1,222	2,365	1,983
83	2,248	2,830	3,140	1,235	2,395	2,009
84	2,274	2,863	3,175	1,249	2,423	2,034
85	2,301	2,899	3,210	1,263	2,452	2,057
86	2,328	2,933	3,242	1,277	2,480	2,080
87	2,350	2,962	3,273	1,287	2,507	2,102
88	2,374	2,992	3,305	1,300	2,532	2,124
89	2,398	3,020	3,335	1,311	2,555	2,144
90	2,416	3,047	3,361	1,322	2,578	2,163
91	2,439	3,072	3,387	1,333	2,599	2,182
92	2,459	3,094	3,409	1,340	2,618	2,198
93	2,476	3,116	3,430	1,349	2,636	2,213
94	2,491	3,137	3,448	1,357	2,654	2,227
95	2,505	3,157	3,465	1,363	2,670	2,239
96	2,519	3,175	3,486	1,371	2,685	2,252
97	2,535	3,194	3,502	1,378	2,702	2,266
98	2,550	3,212	3,519	1,384	2,717	2,280
99	2,563	3,231	3,538	1,391	2,734	2,292

Quarterly: 0.2650 Monthly: 0.0833

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

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

American Continental Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of State

Female Rates

Rates Effective 10/01/2016

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	975	1,230	1,429	562	1,041	873
66	975	1,230	1,429	562	1,041	873
67	975	1,230	1,429	562	1,041	873
68	1,018	1,281	1,487	585	1,084	909
69	1,062	1,338	1,545	608	1,132	950
70	1,104	1,394	1,602	630	1,177	988
71	1,147	1,444	1,658	652	1,222	1,025
72	1,187	1,495	1,710	673	1,264	1,062
73	1,224	1,543	1,756	691	1,305	1,094
74	1,261	1,587	1,801	709	1,342	1,126
75	1,291	1,627	1,842	724	1,376	1,155
76	1,322	1,664	1,878	740	1,408	1,182
77	1,350	1,698	1,911	752	1,438	1,208
78	1,374	1,732	1,940	764	1,467	1,231
79	1,400	1,763	1,967	774	1,492	1,251
80	1,422	1,791	1,992	784	1,516	1,272
81	1,442	1,815	2,018	794	1,538	1,290
82	1,460	1,842	2,044	804	1,557	1,307
83	1,481	1,866	2,067	814	1,578	1,324
84	1,499	1,888	2,091	823	1,598	1,342
85	1,516	1,911	2,116	833	1,616	1,356
86	1,534	1,931	2,136	840	1,634	1,370
87	1,549	1,952	2,158	849	1,652	1,386
88	1,564	1,972	2,178	858	1,669	1,400
89	1,580	1,990	2,195	863	1,684	1,413
90	1,593	2,007	2,215	871	1,698	1,426
91	1,606	2,026	2,233	878	1,713	1,437
92	1,618	2,042	2,247	883	1,726	1,447
93	1,629	2,054	2,261	890	1,738	1,458
94	1,642	2,067	2,273	894	1,750	1,467
95	1,650	2,078	2,285	898	1,761	1,477
96	1,662	2,091	2,297	904	1,770	1,486
97	1,670	2,103	2,308	908	1,780	1,493
98	1,679	2,117	2,321	914	1,790	1,502
99	1,690	2,130	2,331	917	1,801	1,511

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,084	1,367	1,587	624	1,156	970
66	1,084	1,367	1,587	624	1,156	970
67	1,084	1,367	1,587	624	1,156	970
68	1,129	1,423	1,652	650	1,204	1,011
69	1,181	1,486	1,718	676	1,259	1,056
70	1,226	1,546	1,780	699	1,309	1,098
71	1,274	1,606	1,842	724	1,358	1,138
72	1,318	1,662	1,900	746	1,406	1,179
73	1,359	1,714	1,951	768	1,450	1,216
74	1,400	1,763	2,002	788	1,492	1,252
75	1,434	1,808	2,047	805	1,529	1,283
76	1,466	1,850	2,086	821	1,565	1,313
77	1,499	1,889	2,122	836	1,598	1,342
78	1,528	1,925	2,156	848	1,630	1,366
79	1,555	1,960	2,185	859	1,657	1,390
80	1,580	1,990	2,214	870	1,684	1,413
81	1,602	2,019	2,241	882	1,708	1,434
82	1,624	2,046	2,270	894	1,730	1,453
83	1,645	2,072	2,298	904	1,754	1,471
84	1,665	2,098	2,325	914	1,776	1,489
85	1,684	2,122	2,350	925	1,796	1,506
86	1,704	2,147	2,374	934	1,817	1,525
87	1,721	2,169	2,397	942	1,835	1,540
88	1,739	2,191	2,420	952	1,854	1,555
89	1,755	2,211	2,442	960	1,870	1,570
90	1,773	2,232	2,461	967	1,888	1,584
91	1,786	2,249	2,479	975	1,904	1,595
92	1,799	2,266	2,498	984	1,918	1,610
93	1,811	2,283	2,512	988	1,931	1,619
94	1,823	2,298	2,526	994	1,944	1,631
95	1,834	2,312	2,538	998	1,954	1,642
96	1,844	2,325	2,552	1,002	1,966	1,650
97	1,857	2,338	2,565	1,010	1,978	1,658
98	1,866	2,350	2,578	1,014	1,990	1,669
99	1,878	2,366	2,591	1,019	2,002	1,680

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

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

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

American Continental Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of State

Male Rates

Rates Effective 10/01/2016

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,122	1,414	1,643	647	1,196	1,004
66	1,122	1,414	1,643	647	1,196	1,004
67	1,122	1,414	1,643	647	1,196	1,004
68	1,169	1,474	1,710	673	1,246	1,046
69	1,222	1,540	1,778	699	1,302	1,094
70	1,270	1,601	1,843	725	1,354	1,136
71	1,319	1,662	1,906	752	1,406	1,179
72	1,366	1,719	1,967	774	1,454	1,220
73	1,408	1,774	2,019	794	1,500	1,259
74	1,448	1,824	2,072	816	1,544	1,295
75	1,486	1,870	2,118	834	1,583	1,328
76	1,518	1,914	2,158	849	1,619	1,358
77	1,550	1,954	2,195	863	1,654	1,388
78	1,582	1,993	2,232	878	1,685	1,415
79	1,609	2,027	2,262	890	1,714	1,439
80	1,636	2,059	2,290	902	1,742	1,462
81	1,658	2,090	2,321	914	1,768	1,483
82	1,682	2,118	2,350	925	1,791	1,503
83	1,703	2,146	2,378	936	1,814	1,521
84	1,722	2,170	2,406	947	1,838	1,541
85	1,744	2,195	2,433	956	1,858	1,560
86	1,763	2,221	2,457	966	1,879	1,577
87	1,781	2,246	2,482	976	1,899	1,593
88	1,800	2,267	2,505	986	1,918	1,610
89	1,815	2,290	2,527	994	1,936	1,626
90	1,834	2,309	2,546	1,001	1,954	1,639
91	1,848	2,327	2,566	1,010	1,970	1,653
92	1,861	2,346	2,582	1,017	1,985	1,665
93	1,877	2,364	2,600	1,022	1,998	1,677
94	1,886	2,378	2,614	1,030	2,012	1,687
95	1,897	2,391	2,627	1,034	2,023	1,698
96	1,908	2,406	2,640	1,038	2,034	1,707
97	1,920	2,418	2,654	1,044	2,047	1,718
98	1,931	2,434	2,668	1,050	2,059	1,728
99	1,942	2,449	2,682	1,054	2,072	1,738

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,246	1,570	1,824	718	1,330	1,116
66	1,246	1,570	1,824	718	1,330	1,116
67	1,246	1,570	1,824	718	1,330	1,116
68	1,298	1,636	1,901	746	1,385	1,162
69	1,356	1,710	1,974	778	1,447	1,214
70	1,412	1,778	2,047	805	1,506	1,263
71	1,466	1,846	2,118	834	1,562	1,310
72	1,516	1,911	2,185	859	1,615	1,356
73	1,564	1,970	2,243	882	1,667	1,398
74	1,609	2,027	2,302	906	1,714	1,439
75	1,649	2,078	2,354	927	1,758	1,476
76	1,687	2,126	2,399	944	1,799	1,510
77	1,723	2,174	2,442	960	1,838	1,541
78	1,756	2,214	2,478	974	1,872	1,571
79	1,787	2,254	2,513	988	1,905	1,598
80	1,815	2,288	2,545	1,001	1,936	1,625
81	1,842	2,322	2,578	1,014	1,965	1,648
82	1,867	2,352	2,611	1,029	1,991	1,670
83	1,893	2,383	2,644	1,040	2,017	1,692
84	1,915	2,411	2,674	1,052	2,041	1,713
85	1,938	2,442	2,703	1,063	2,065	1,732
86	1,960	2,470	2,730	1,075	2,089	1,751
87	1,979	2,494	2,756	1,084	2,111	1,770
88	1,999	2,519	2,783	1,094	2,132	1,789
89	2,019	2,543	2,808	1,104	2,151	1,806
90	2,034	2,566	2,830	1,114	2,171	1,822
91	2,054	2,587	2,852	1,122	2,189	1,838
92	2,070	2,606	2,870	1,128	2,205	1,851
93	2,085	2,624	2,889	1,136	2,220	1,863
94	2,098	2,642	2,903	1,142	2,235	1,875
95	2,110	2,658	2,918	1,148	2,248	1,886
96	2,122	2,674	2,935	1,154	2,261	1,897
97	2,134	2,690	2,949	1,160	2,275	1,908
98	2,147	2,705	2,963	1,166	2,288	1,920
99	2,158	2,721	2,979	1,171	2,302	1,930

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

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

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

PREMIUM INFORMATION

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

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

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

DISCLOSURES

Use this outline to compare benefits and premium among policies.

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	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $161 a day	$0	Up to $161 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN A

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

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

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

PARTS A & B

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

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $161 a day	$0	Up to $161 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN B

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

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

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

PARTS A & B

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

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $161 a day	Up to $161 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN F

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

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

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

PARTS A & B

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

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE 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.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $161 a day	Up to $161 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

HIGH DEDUCTIBLE PLAN F

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

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

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE*** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $166 of Medicare-Approved amounts*	$0	$166 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $166 of Medicare-Approved amounts*	$0	$166 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $166 of Medicare Approved amounts*	$0	$166 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $161 a day	Up to $161 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN G

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

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

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

PARTS A & B

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

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $161 a day	Up to $161 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $166 of Medicare-Approved amounts*	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-Approved amounts)	$0	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $166 of Medicare-Approved amounts*	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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