800 Crescent Centre Dr.
Suite 200
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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**

Virginia

ACIMS01053VA

Rates Effective: 08/2016 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" and Plan "B". Some plans may not be available in your state.

See Outlines of Coverage section for details about ALL plans

Basic Benefits:
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-Approved expenses) or, copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of coinsurance or copayments
Blood: First three pints of blood each year.
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: 230-237

Female Rates

Rates Effective 8/1/2016

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,220	1,540	1,811	477	1,139	979
66	1,220	1,540	1,811	477	1,139	979
67	1,220	1,540	1,811	477	1,139	979
68	1,274	1,602	1,887	497	1,187	1,022
69	1,329	1,674	1,960	518	1,241	1,067
70	1,382	1,742	2,033	536	1,289	1,108
71	1,436	1,808	2,104	554	1,338	1,152
72	1,485	1,870	2,169	572	1,385	1,192
73	1,531	1,931	2,227	587	1,429	1,229
74	1,578	1,985	2,283	603	1,470	1,264
75	1,616	2,036	2,336	616	1,507	1,297
76	1,655	2,082	2,382	629	1,542	1,326
77	1,688	2,126	2,425	638	1,575	1,356
78	1,720	2,168	2,461	649	1,606	1,381
79	1,751	2,206	2,495	658	1,633	1,404
80	1,780	2,240	2,526	667	1,660	1,428
81	1,805	2,273	2,559	674	1,682	1,447
82	1,828	2,303	2,592	684	1,706	1,468
83	1,854	2,334	2,624	692	1,728	1,486
84	1,877	2,363	2,652	700	1,750	1,506
85	1,896	2,392	2,685	708	1,770	1,522
86	1,919	2,417	2,710	716	1,789	1,538
87	1,938	2,444	2,740	722	1,809	1,555
88	1,958	2,468	2,764	729	1,826	1,571
89	1,976	2,491	2,786	734	1,844	1,587
90	1,995	2,511	2,810	740	1,859	1,601
91	2,011	2,534	2,832	747	1,877	1,613
92	2,025	2,554	2,849	751	1,890	1,625
93	2,040	2,571	2,869	757	1,904	1,637
94	2,054	2,588	2,883	761	1,916	1,647
95	2,066	2,601	2,898	763	1,927	1,657
96	2,077	2,616	2,913	769	1,939	1,667
97	2,089	2,634	2,928	772	1,949	1,676
98	2,102	2,648	2,943	778	1,961	1,685
99	2,115	2,665	2,956	779	1,972	1,697

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,356	1,711	2,013	530	1,265	1,089
66	1,356	1,711	2,013	530	1,265	1,089
67	1,356	1,711	2,013	530	1,265	1,089
68	1,413	1,781	2,095	553	1,318	1,133
69	1,476	1,859	2,180	574	1,378	1,186
70	1,535	1,934	2,260	595	1,433	1,234
71	1,594	2,010	2,336	616	1,486	1,278
72	1,649	2,078	2,409	636	1,539	1,324
73	1,701	2,145	2,476	653	1,589	1,365
74	1,751	2,206	2,541	669	1,633	1,406
75	1,794	2,262	2,597	684	1,674	1,439
76	1,836	2,314	2,646	698	1,714	1,472
77	1,877	2,363	2,692	710	1,750	1,506
78	1,913	2,408	2,733	721	1,784	1,535
79	1,946	2,452	2,771	730	1,814	1,560
80	1,976	2,491	2,807	740	1,844	1,587
81	2,005	2,525	2,844	749	1,870	1,609
82	2,031	2,561	2,880	761	1,895	1,630
83	2,058	2,593	2,914	769	1,920	1,651
84	2,084	2,625	2,949	778	1,944	1,672
85	2,106	2,656	2,981	788	1,967	1,691
86	2,131	2,687	3,013	795	1,988	1,710
87	2,156	2,714	3,042	801	2,010	1,729
88	2,177	2,741	3,071	810	2,030	1,746
89	2,196	2,768	3,097	816	2,048	1,762
90	2,218	2,793	3,121	824	2,067	1,778
91	2,234	2,814	3,144	828	2,084	1,793
92	2,251	2,836	3,167	835	2,100	1,807
93	2,267	2,858	3,188	841	2,114	1,820
94	2,282	2,875	3,204	845	2,129	1,832
95	2,296	2,892	3,220	849	2,139	1,842
96	2,308	2,909	3,236	853	2,154	1,850
97	2,322	2,927	3,254	859	2,165	1,862
98	2,336	2,942	3,271	861	2,178	1,873
99	2,351	2,963	3,286	866	2,192	1,885

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

The rates do not include the $20 policy fee.

To calculate household discount:

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

Modal premium x .95 = discounted premium

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

American Continental Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: 230-237

Male Rates

Rates Effective 8/1/2016

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,404	1,768	2,083	550	1,310	1,126
66	1,404	1,768	2,083	550	1,310	1,126
67	1,404	1,768	2,083	550	1,310	1,126
68	1,463	1,844	2,169	572	1,364	1,174
69	1,529	1,927	2,255	594	1,426	1,227
70	1,589	2,002	2,337	617	1,483	1,275
71	1,650	2,078	2,419	637	1,539	1,324
72	1,708	2,151	2,495	658	1,592	1,371
73	1,762	2,219	2,561	674	1,643	1,412
74	1,813	2,284	2,628	693	1,690	1,454
75	1,857	2,340	2,687	708	1,733	1,491
76	1,900	2,394	2,740	722	1,774	1,524
77	1,940	2,445	2,786	734	1,811	1,557
78	1,979	2,494	2,831	747	1,846	1,589
79	2,012	2,535	2,871	757	1,878	1,616
80	2,047	2,577	2,906	766	1,909	1,641
81	2,075	2,614	2,943	778	1,936	1,665
82	2,102	2,650	2,981	788	1,961	1,687
83	2,130	2,685	3,017	795	1,987	1,709
84	2,156	2,716	3,050	805	2,012	1,729
85	2,182	2,748	3,085	814	2,036	1,750
86	2,206	2,780	3,118	823	2,058	1,770
87	2,229	2,810	3,150	831	2,079	1,788
88	2,251	2,838	3,178	838	2,101	1,808
89	2,273	2,865	3,205	845	2,122	1,824
90	2,295	2,890	3,231	851	2,139	1,839
91	2,313	2,914	3,254	859	2,157	1,856
92	2,328	2,936	3,277	864	2,173	1,869
93	2,347	2,957	3,297	869	2,189	1,883
94	2,362	2,976	3,317	875	2,202	1,895
95	2,375	2,992	3,333	879	2,216	1,905
96	2,390	3,009	3,350	883	2,228	1,916
97	2,404	3,029	3,366	888	2,241	1,929
98	2,417	3,044	3,384	893	2,255	1,940
99	2,431	3,064	3,402	896	2,268	1,951

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,559	1,964	2,316	609	1,454	1,253
66	1,559	1,964	2,316	609	1,454	1,253
67	1,559	1,964	2,316	609	1,454	1,253
68	1,625	2,048	2,410	636	1,516	1,304
69	1,697	2,139	2,506	661	1,585	1,362
70	1,765	2,226	2,597	684	1,649	1,418
71	1,832	2,310	2,687	708	1,711	1,472
72	1,896	2,392	2,771	730	1,769	1,522
73	1,958	2,466	2,846	750	1,825	1,571
74	2,012	2,535	2,921	770	1,878	1,616
75	2,065	2,601	2,986	788	1,925	1,656
76	2,113	2,659	3,043	802	1,970	1,696
77	2,157	2,718	3,097	816	2,012	1,729
78	2,197	2,769	3,144	828	2,050	1,764
79	2,237	2,820	3,189	841	2,087	1,794
80	2,273	2,863	3,227	851	2,121	1,823
81	2,305	2,904	3,272	861	2,152	1,849
82	2,336	2,943	3,312	875	2,182	1,874
83	2,367	2,981	3,353	884	2,208	1,899
84	2,395	3,019	3,391	894	2,235	1,923
85	2,426	3,056	3,429	904	2,262	1,944
86	2,452	3,090	3,463	913	2,287	1,967
87	2,476	3,121	3,497	922	2,311	1,987
88	2,503	3,151	3,531	931	2,334	2,008
89	2,525	3,183	3,561	939	2,356	2,027
90	2,546	3,211	3,590	947	2,378	2,045
91	2,570	3,238	3,616	953	2,397	2,062
92	2,589	3,263	3,641	959	2,415	2,077
93	2,608	3,285	3,662	967	2,432	2,092
94	2,624	3,306	3,685	970	2,447	2,105
95	2,638	3,327	3,702	977	2,462	2,116
96	2,655	3,346	3,722	981	2,477	2,129
97	2,670	3,364	3,740	986	2,490	2,141
98	2,687	3,384	3,760	991	2,505	2,155
99	2,702	3,404	3,779	996	2,520	2,168

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

The rates do not include the $20 policy fee.

To calculate household discount:

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

Modal premium x .95 = discounted premium

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

American Continental Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: 220-225

Female Rates

Rates Effective 8/1/2016

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,355	1,711	2,012	530	1,266	1,088
66	1,355	1,711	2,012	530	1,266	1,088
67	1,355	1,711	2,012	530	1,266	1,088
68	1,415	1,780	2,097	552	1,319	1,135
69	1,477	1,860	2,178	575	1,379	1,186
70	1,536	1,935	2,259	596	1,432	1,231
71	1,595	2,009	2,338	615	1,487	1,280
72	1,650	2,078	2,410	635	1,539	1,324
73	1,701	2,145	2,474	652	1,588	1,365
74	1,753	2,206	2,537	670	1,633	1,404
75	1,796	2,262	2,596	684	1,674	1,441
76	1,839	2,313	2,647	699	1,713	1,473
77	1,876	2,362	2,694	709	1,750	1,507
78	1,911	2,409	2,734	721	1,784	1,534
79	1,946	2,451	2,772	731	1,814	1,560
80	1,978	2,489	2,807	741	1,844	1,587
81	2,005	2,525	2,843	749	1,869	1,608
82	2,031	2,559	2,880	760	1,895	1,631
83	2,060	2,593	2,915	769	1,920	1,651
84	2,085	2,625	2,947	778	1,944	1,673
85	2,107	2,658	2,983	787	1,967	1,691
86	2,132	2,686	3,011	795	1,988	1,709
87	2,153	2,715	3,044	802	2,010	1,728
88	2,176	2,742	3,071	810	2,029	1,746
89	2,195	2,768	3,095	816	2,049	1,763
90	2,217	2,790	3,122	822	2,066	1,779
91	2,234	2,815	3,147	830	2,085	1,792
92	2,250	2,838	3,165	834	2,100	1,806
93	2,267	2,857	3,188	841	2,115	1,819
94	2,282	2,875	3,203	845	2,129	1,830
95	2,295	2,890	3,220	848	2,141	1,841
96	2,308	2,907	3,237	854	2,154	1,852
97	2,321	2,927	3,253	858	2,166	1,862
98	2,335	2,942	3,270	864	2,179	1,872
99	2,350	2,961	3,284	866	2,191	1,886

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,507	1,901	2,237	589	1,406	1,210
66	1,507	1,901	2,237	589	1,406	1,210
67	1,507	1,901	2,237	589	1,406	1,210
68	1,570	1,979	2,328	614	1,464	1,259
69	1,640	2,066	2,422	638	1,531	1,318
70	1,705	2,149	2,511	661	1,592	1,371
71	1,771	2,233	2,596	684	1,651	1,420
72	1,832	2,309	2,677	707	1,710	1,471
73	1,890	2,383	2,751	725	1,765	1,517
74	1,946	2,451	2,823	743	1,814	1,562
75	1,993	2,513	2,886	760	1,860	1,599
76	2,040	2,571	2,940	775	1,904	1,635
77	2,086	2,626	2,991	789	1,944	1,673
78	2,125	2,675	3,037	801	1,982	1,705
79	2,162	2,724	3,079	811	2,016	1,733
80	2,195	2,768	3,119	822	2,049	1,763
81	2,228	2,805	3,160	832	2,078	1,788
82	2,257	2,845	3,200	845	2,106	1,811
83	2,287	2,881	3,238	854	2,133	1,834
84	2,315	2,917	3,277	864	2,160	1,858
85	2,340	2,951	3,312	875	2,186	1,879
86	2,368	2,986	3,348	883	2,209	1,900
87	2,395	3,016	3,380	890	2,233	1,921
88	2,419	3,045	3,412	900	2,256	1,940
89	2,440	3,075	3,441	907	2,276	1,958
90	2,464	3,103	3,468	915	2,297	1,975
91	2,482	3,127	3,493	920	2,316	1,992
92	2,501	3,151	3,519	928	2,333	2,008
93	2,519	3,176	3,542	934	2,349	2,022
94	2,536	3,194	3,560	939	2,365	2,035
95	2,551	3,213	3,578	943	2,377	2,047
96	2,564	3,232	3,596	948	2,393	2,056
97	2,580	3,252	3,615	954	2,406	2,069
98	2,595	3,269	3,634	957	2,420	2,081
99	2,612	3,292	3,651	962	2,435	2,094

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

The rates do not include the $20 policy fee.

To calculate household discount:

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

Modal premium x .95 = discounted premium

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

American Continental Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: 220-225

Male Rates

Rates Effective 8/1/2016

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,560	1,964	2,314	611	1,455	1,251
66	1,560	1,964	2,314	611	1,455	1,251
67	1,560	1,964	2,314	611	1,455	1,251
68	1,625	2,049	2,410	635	1,516	1,304
69	1,699	2,141	2,505	660	1,584	1,363
70	1,766	2,224	2,597	685	1,648	1,417
71	1,833	2,309	2,688	708	1,710	1,471
72	1,898	2,390	2,772	731	1,769	1,523
73	1,958	2,465	2,846	749	1,825	1,569
74	2,014	2,538	2,920	770	1,878	1,616
75	2,063	2,600	2,986	787	1,925	1,657
76	2,111	2,660	3,044	802	1,971	1,693
77	2,155	2,717	3,095	816	2,012	1,730
78	2,199	2,771	3,146	830	2,051	1,765
79	2,236	2,817	3,190	841	2,087	1,795
80	2,274	2,863	3,229	851	2,121	1,823
81	2,306	2,904	3,270	864	2,151	1,850
82	2,336	2,944	3,312	875	2,179	1,874
83	2,367	2,983	3,352	883	2,208	1,899
84	2,396	3,018	3,389	894	2,236	1,921
85	2,424	3,053	3,428	904	2,262	1,944
86	2,451	3,089	3,464	914	2,287	1,967
87	2,477	3,122	3,500	923	2,310	1,987
88	2,501	3,153	3,531	931	2,334	2,009
89	2,525	3,183	3,561	939	2,358	2,027
90	2,550	3,211	3,590	946	2,377	2,043
91	2,570	3,238	3,616	954	2,397	2,062
92	2,587	3,262	3,641	960	2,414	2,077
93	2,608	3,286	3,663	966	2,432	2,092
94	2,624	3,307	3,685	972	2,447	2,105
95	2,639	3,324	3,703	977	2,462	2,117
96	2,655	3,343	3,722	981	2,476	2,129
97	2,671	3,365	3,740	987	2,490	2,143
98	2,686	3,382	3,760	992	2,506	2,155
99	2,701	3,404	3,780	996	2,520	2,168

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,732	2,182	2,573	677	1,616	1,392
66	1,732	2,182	2,573	677	1,616	1,392
67	1,732	2,182	2,573	677	1,616	1,392
68	1,805	2,275	2,678	707	1,684	1,449
69	1,886	2,377	2,784	734	1,761	1,513
70	1,961	2,473	2,886	760	1,832	1,575
71	2,036	2,567	2,986	787	1,901	1,635
72	2,107	2,658	3,079	811	1,966	1,691
73	2,175	2,740	3,162	833	2,028	1,745
74	2,236	2,817	3,245	855	2,087	1,795
75	2,294	2,890	3,318	876	2,139	1,840
76	2,348	2,954	3,381	891	2,189	1,884
77	2,397	3,020	3,441	907	2,236	1,921
78	2,441	3,077	3,493	920	2,278	1,960
79	2,485	3,133	3,543	934	2,319	1,993
80	2,525	3,181	3,586	946	2,357	2,026
81	2,561	3,227	3,635	957	2,391	2,054
82	2,596	3,270	3,680	972	2,424	2,082
83	2,630	3,312	3,725	982	2,453	2,110
84	2,661	3,354	3,768	993	2,483	2,137
85	2,696	3,395	3,810	1,004	2,513	2,160
86	2,724	3,433	3,848	1,014	2,541	2,185
87	2,751	3,468	3,886	1,024	2,568	2,208
88	2,781	3,501	3,923	1,034	2,593	2,231
89	2,805	3,537	3,957	1,043	2,618	2,252
90	2,829	3,568	3,989	1,052	2,642	2,272
91	2,856	3,598	4,018	1,059	2,663	2,291
92	2,877	3,626	4,045	1,066	2,683	2,308
93	2,898	3,650	4,069	1,074	2,702	2,324
94	2,916	3,673	4,094	1,078	2,719	2,339
95	2,931	3,697	4,113	1,085	2,735	2,351
96	2,950	3,718	4,135	1,090	2,752	2,366
97	2,967	3,738	4,156	1,095	2,767	2,379
98	2,986	3,760	4,178	1,101	2,783	2,394
99	3,002	3,782	4,199	1,107	2,800	2,409

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

The rates do not include the $20 policy fee.

To calculate household discount:

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

Modal premium x .95 = discounted premium

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

American Continental Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of State

Female Rates

Rates Effective 8/1/2016

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,084	1,369	1,610	424	1,013	870
66	1,084	1,369	1,610	424	1,013	870
67	1,084	1,369	1,610	424	1,013	870
68	1,132	1,424	1,678	442	1,055	908
69	1,182	1,488	1,742	460	1,103	949
70	1,229	1,548	1,807	477	1,146	985
71	1,276	1,607	1,870	492	1,190	1,024
72	1,320	1,662	1,928	508	1,231	1,059
73	1,361	1,716	1,979	522	1,270	1,092
74	1,402	1,765	2,030	536	1,306	1,123
75	1,437	1,810	2,077	547	1,339	1,153
76	1,471	1,850	2,118	559	1,370	1,178
77	1,501	1,890	2,155	567	1,400	1,206
78	1,529	1,927	2,187	577	1,427	1,227
79	1,557	1,961	2,218	585	1,451	1,248
80	1,582	1,991	2,246	593	1,475	1,270
81	1,604	2,020	2,274	599	1,495	1,286
82	1,625	2,047	2,304	608	1,516	1,305
83	1,648	2,074	2,332	615	1,536	1,321
84	1,668	2,100	2,358	622	1,555	1,338
85	1,686	2,126	2,386	630	1,574	1,353
86	1,706	2,149	2,409	636	1,590	1,367
87	1,722	2,172	2,435	642	1,608	1,382
88	1,741	2,194	2,457	648	1,623	1,397
89	1,756	2,214	2,476	653	1,639	1,410
90	1,774	2,232	2,498	658	1,653	1,423
91	1,787	2,252	2,518	664	1,668	1,434
92	1,800	2,270	2,532	667	1,680	1,445
93	1,814	2,286	2,550	673	1,692	1,455
94	1,826	2,300	2,562	676	1,703	1,464
95	1,836	2,312	2,576	678	1,713	1,473
96	1,846	2,326	2,590	683	1,723	1,482
97	1,857	2,342	2,602	686	1,733	1,490
98	1,868	2,354	2,616	691	1,743	1,498
99	1,880	2,369	2,627	693	1,753	1,509

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,206	1,521	1,790	471	1,125	968
66	1,206	1,521	1,790	471	1,125	968
67	1,206	1,521	1,790	471	1,125	968
68	1,256	1,583	1,862	491	1,171	1,007
69	1,312	1,653	1,938	510	1,225	1,054
70	1,364	1,719	2,009	529	1,274	1,097
71	1,417	1,786	2,077	547	1,321	1,136
72	1,466	1,847	2,142	566	1,368	1,177
73	1,512	1,906	2,201	580	1,412	1,214
74	1,557	1,961	2,258	594	1,451	1,250
75	1,594	2,010	2,309	608	1,488	1,279
76	1,632	2,057	2,352	620	1,523	1,308
77	1,669	2,101	2,393	631	1,555	1,338
78	1,700	2,140	2,430	641	1,586	1,364
79	1,730	2,179	2,463	649	1,613	1,386
80	1,756	2,214	2,495	658	1,639	1,410
81	1,782	2,244	2,528	666	1,662	1,430
82	1,806	2,276	2,560	676	1,685	1,449
83	1,830	2,305	2,590	683	1,706	1,467
84	1,852	2,334	2,622	691	1,728	1,486
85	1,872	2,361	2,650	700	1,749	1,503
86	1,894	2,389	2,678	706	1,767	1,520
87	1,916	2,413	2,704	712	1,786	1,537
88	1,935	2,436	2,730	720	1,805	1,552
89	1,952	2,460	2,753	726	1,821	1,566
90	1,971	2,482	2,774	732	1,838	1,580
91	1,986	2,502	2,794	736	1,853	1,594
92	2,001	2,521	2,815	742	1,866	1,606
93	2,015	2,541	2,834	747	1,879	1,618
94	2,029	2,555	2,848	751	1,892	1,628
95	2,041	2,570	2,862	754	1,902	1,638
96	2,051	2,586	2,877	758	1,914	1,645
97	2,064	2,602	2,892	763	1,925	1,655
98	2,076	2,615	2,907	766	1,936	1,665
99	2,090	2,634	2,921	770	1,948	1,675

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

The rates do not include the $20 policy fee.

To calculate household discount:

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

Modal premium x .95 = discounted premium

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

American Continental Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of State

Male Rates

Rates Effective 8/1/2016

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,248	1,571	1,851	489	1,164	1,001
66	1,248	1,571	1,851	489	1,164	1,001
67	1,248	1,571	1,851	489	1,164	1,001
68	1,300	1,639	1,928	508	1,213	1,043
69	1,359	1,713	2,004	528	1,267	1,090
70	1,413	1,779	2,078	548	1,318	1,134
71	1,466	1,847	2,150	566	1,368	1,177
72	1,518	1,912	2,218	585	1,415	1,218
73	1,566	1,972	2,277	599	1,460	1,255
74	1,611	2,030	2,336	616	1,502	1,293
75	1,650	2,080	2,389	630	1,540	1,326
76	1,689	2,128	2,435	642	1,577	1,354
77	1,724	2,174	2,476	653	1,610	1,384
78	1,759	2,217	2,517	664	1,641	1,412
79	1,789	2,254	2,552	673	1,670	1,436
80	1,819	2,290	2,583	681	1,697	1,458
81	1,845	2,323	2,616	691	1,721	1,480
82	1,869	2,355	2,650	700	1,743	1,499
83	1,894	2,386	2,682	706	1,766	1,519
84	1,917	2,414	2,711	715	1,789	1,537
85	1,939	2,442	2,742	723	1,810	1,555
86	1,961	2,471	2,771	731	1,830	1,574
87	1,982	2,498	2,800	738	1,848	1,590
88	2,001	2,522	2,825	745	1,867	1,607
89	2,020	2,546	2,849	751	1,886	1,622
90	2,040	2,569	2,872	757	1,902	1,634
91	2,056	2,590	2,893	763	1,918	1,650
92	2,070	2,610	2,913	768	1,931	1,662
93	2,086	2,629	2,930	773	1,946	1,674
94	2,099	2,646	2,948	778	1,958	1,684
95	2,111	2,659	2,962	782	1,970	1,694
96	2,124	2,674	2,978	785	1,981	1,703
97	2,137	2,692	2,992	790	1,992	1,714
98	2,149	2,706	3,008	794	2,005	1,724
99	2,161	2,723	3,024	797	2,016	1,734

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,386	1,746	2,058	542	1,293	1,114
66	1,386	1,746	2,058	542	1,293	1,114
67	1,386	1,746	2,058	542	1,293	1,114
68	1,444	1,820	2,142	566	1,347	1,159
69	1,509	1,902	2,227	587	1,409	1,210
70	1,569	1,978	2,309	608	1,466	1,260
71	1,629	2,054	2,389	630	1,521	1,308
72	1,686	2,126	2,463	649	1,573	1,353
73	1,740	2,192	2,530	666	1,622	1,396
74	1,789	2,254	2,596	684	1,670	1,436
75	1,835	2,312	2,654	701	1,711	1,472
76	1,878	2,363	2,705	713	1,751	1,507
77	1,918	2,416	2,753	726	1,789	1,537
78	1,953	2,462	2,794	736	1,822	1,568
79	1,988	2,506	2,834	747	1,855	1,594
80	2,020	2,545	2,869	757	1,886	1,621
81	2,049	2,582	2,908	766	1,913	1,643
82	2,077	2,616	2,944	778	1,939	1,666
83	2,104	2,650	2,980	786	1,962	1,688
84	2,129	2,683	3,014	794	1,986	1,710
85	2,157	2,716	3,048	803	2,010	1,728
86	2,179	2,746	3,078	811	2,033	1,748
87	2,201	2,774	3,109	819	2,054	1,766
88	2,225	2,801	3,138	827	2,074	1,785
89	2,244	2,830	3,166	834	2,094	1,802
90	2,263	2,854	3,191	842	2,114	1,818
91	2,285	2,878	3,214	847	2,130	1,833
92	2,302	2,901	3,236	853	2,146	1,846
93	2,318	2,920	3,255	859	2,162	1,859
94	2,333	2,938	3,275	862	2,175	1,871
95	2,345	2,958	3,290	868	2,188	1,881
96	2,360	2,974	3,308	872	2,202	1,893
97	2,374	2,990	3,325	876	2,214	1,903
98	2,389	3,008	3,342	881	2,226	1,915
99	2,402	3,026	3,359	886	2,240	1,927

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

The rates do not include the $20 policy fee.

To calculate 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

Premiums for this American Continental Insurance Company policy are attained age rated. Premiums for this policy will increase each year as you get older. Premiums for other Medicare Supplement policies that are issue age rated do not increase due to the change in your age. While the cost of this policy at your present age may be lower than the cost of a Medicare supplement policy that is based on issue age or community rated, it is important to compare the potential cost of these policies over the life of the policy.

We guarantee to renew this Policy during your lifetime as long as You pay Your renewal premiums on time, either in advance or during the grace period. Your policy will end on the date any required premium is due and unpaid subject to the thirty-one (31) day Grace Period. We may not cancel or nonrenew this Policy solely on the ground of Your health status. We also may not cancel or nonrenew this Policy for a reason other than nonpayment of premium or material misrepresentation.

Your premium will change on the first renewal date that coincides with or follows each Anniversary of the Effective Date. The new premium will be based upon your age at that time. Additionally, We reserve the right to revise the table of premium rates. If We make such a change of premium, We will provide to You advance notice.

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) someone with whom you have continuously resided for the past 12 months. The household discount will only be applicable if a policy for each applicant is issued. The discounted rate will be 5 percent lower than the individual rates and will apply as long as both policies remain in force.

DISCLOSURE

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 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.	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