



800 Crescent Centre Dr.
Suite 200
Franklin, TN 37067
800 264.4000
aetnaseniorproducts.com

Outline of Coverage

Medicare Supplement Insurance

BENEFIT PLANS A, B, F, HIGH DEDUCTIBLE F, G, N

Underwritten by
An Aetna Company **American Continental
Insurance Company**

Tennessee

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.

See Outlines of Coverage sections for details about ALL plans

Basic Benefits:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-Approved expenses) or, co-payments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of coinsurance or copayments

Blood: First three pints of blood each year.

Hospice: Part A coinsurance

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

*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: All

Female Rates

Rates Effective 06/01/2016

Attained Age	Preferred					Standard							
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	
Under 65	4,432	5,590	6,579	2,364	4,503	3,783	n/a	n/a	n/a	n/a	n/a	n/a	
65	1,209	1,524	1,796	643	1,228	1,031	1,345	1,694	1,995	716	1,363	1,147	
66	1,210	1,526	1,796	644	1,230	1,032	1,347	1,696	1,996	717	1,365	1,148	
67	1,211	1,527	1,798	645	1,231	1,033	1,348	1,697	1,998	718	1,366	1,149	
68	1,262	1,591	1,872	673	1,282	1,078	1,404	1,768	2,080	749	1,425	1,197	
69	1,318	1,663	1,945	700	1,339	1,125	1,464	1,846	2,163	777	1,488	1,252	
70	1,373	1,730	2,017	726	1,392	1,169	1,524	1,919	2,242	804	1,547	1,300	
71	1,425	1,793	2,086	750	1,447	1,215	1,581	1,995	2,317	833	1,608	1,350	
72	1,474	1,858	2,152	773	1,497	1,257	1,637	2,062	2,391	859	1,663	1,396	
73	1,520	1,915	2,211	794	1,543	1,297	1,689	2,127	2,458	884	1,715	1,441	
74	1,564	1,971	2,268	815	1,589	1,333	1,737	2,189	2,519	906	1,764	1,483	
75	1,603	2,019	2,317	833	1,628	1,367	1,782	2,244	2,578	926	1,809	1,520	
76	1,641	2,068	2,364	851	1,667	1,399	1,822	2,295	2,624	943	1,851	1,554	
77	1,675	2,111	2,406	864	1,701	1,430	1,861	2,344	2,673	961	1,891	1,589	
78	1,706	2,150	2,442	877	1,735	1,458	1,897	2,389	2,713	974	1,927	1,620	
79	1,737	2,189	2,477	888	1,764	1,482	1,930	2,432	2,750	987	1,958	1,647	
80	1,766	2,224	2,506	900	1,792	1,507	1,961	2,470	2,786	1,000	1,993	1,674	
81	1,790	2,255	2,538	912	1,819	1,528	1,990	2,506	2,820	1,014	2,021	1,699	
82	1,814	2,287	2,573	925	1,843	1,549	2,016	2,541	2,858	1,028	2,049	1,721	
83	1,839	2,316	2,604	936	1,866	1,570	2,044	2,572	2,891	1,040	2,075	1,742	
84	1,860	2,344	2,633	948	1,890	1,589	2,068	2,607	2,925	1,050	2,100	1,764	
85	1,882	2,374	2,662	958	1,912	1,607	2,090	2,636	2,958	1,062	2,124	1,785	
86	1,904	2,399	2,690	966	1,933	1,624	2,115	2,666	2,989	1,074	2,148	1,806	
87	1,925	2,425	2,716	975	1,955	1,642	2,138	2,692	3,019	1,083	2,172	1,825	
88	1,943	2,449	2,742	985	1,975	1,659	2,159	2,721	3,046	1,094	2,193	1,841	
89	1,961	2,470	2,764	994	1,993	1,674	2,180	2,745	3,073	1,105	2,214	1,860	
90	1,979	2,493	2,790	1,000	2,010	1,690	2,200	2,771	3,097	1,114	2,234	1,877	
91	1,995	2,514	2,810	1,009	2,028	1,703	2,217	2,793	3,120	1,121	2,251	1,891	
92	2,010	2,534	2,829	1,016	2,041	1,716	2,234	2,815	3,145	1,130	2,269	1,907	
93	2,025	2,552	2,846	1,024	2,056	1,728	2,248	2,835	3,162	1,137	2,286	1,919	
94	2,038	2,568	2,860	1,028	2,071	1,739	2,265	2,852	3,180	1,142	2,300	1,933	
95	2,049	2,582	2,875	1,032	2,082	1,750	2,277	2,869	3,195	1,147	2,313	1,945	
96	2,062	2,598	2,890	1,040	2,093	1,760	2,289	2,886	3,209	1,154	2,325	1,955	
97	2,073	2,612	2,905	1,044	2,107	1,770	2,305	2,903	3,228	1,161	2,340	1,966	
98	2,085	2,627	2,922	1,049	2,119	1,779	2,317	2,920	3,245	1,166	2,352	1,978	
99	2,100	2,644	2,935	1,055	2,131	1,790	2,332	2,939	3,262	1,172	2,368	1,990	
Modal Factors:						Semi-Annual: 0.5200			Quarterly: 0.2650			Monthly: 0.0833	

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

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

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

American Continental Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: All

Male Rates

Rates Effective 06/01/2016

Attained	Preferred						Standard								
	Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N		
Under 65		5,100	6,422	7,568	2,720	5,177	4,349	n/a	n/a	n/a	n/a	n/a	n/a		
65		1,390	1,752	2,066	741	1,413	1,187	1,545	1,947	2,294	823	1,570	1,319		
66		1,392	1,754	2,068	742	1,414	1,188	1,546	1,948	2,296	824	1,572	1,321		
67		1,393	1,756	2,070	743	1,415	1,188	1,548	1,950	2,298	826	1,572	1,322		
68		1,452	1,830	2,152	773	1,474	1,240	1,614	2,032	2,391	859	1,639	1,377		
69		1,517	1,912	2,238	804	1,541	1,295	1,684	2,124	2,485	894	1,712	1,439		
70		1,577	1,985	2,318	834	1,602	1,347	1,753	2,209	2,578	926	1,780	1,497		
71		1,638	2,062	2,400	863	1,663	1,396	1,819	2,292	2,667	959	1,848	1,552		
72		1,694	2,135	2,477	888	1,719	1,446	1,882	2,374	2,750	987	1,912	1,607		
73		1,747	2,202	2,541	912	1,775	1,492	1,941	2,446	2,824	1,015	1,972	1,657		
74		1,799	2,268	2,607	938	1,828	1,535	1,998	2,516	2,897	1,042	2,028	1,705		
75		1,844	2,322	2,667	959	1,873	1,573	2,048	2,581	2,963	1,065	2,080	1,749		
76		1,885	2,376	2,716	975	1,916	1,608	2,098	2,640	3,020	1,086	2,127	1,789		
77		1,926	2,427	2,764	994	1,956	1,644	2,140	2,700	3,073	1,105	2,174	1,826		
78		1,963	2,475	2,809	1,009	1,994	1,676	2,181	2,748	3,120	1,120	2,216	1,861		
79		1,998	2,516	2,848	1,024	2,028	1,705	2,218	2,796	3,164	1,137	2,254	1,893		
80		2,031	2,557	2,884	1,036	2,061	1,734	2,255	2,842	3,204	1,152	2,290	1,925		
81		2,058	2,596	2,922	1,049	2,093	1,758	2,287	2,884	3,247	1,166	2,323	1,954		
82		2,087	2,630	2,958	1,062	2,120	1,780	2,319	2,921	3,286	1,182	2,354	1,978		
83		2,114	2,666	2,993	1,076	2,147	1,803	2,349	2,961	3,326	1,194	2,386	2,004		
84		2,139	2,694	3,028	1,089	2,174	1,826	2,378	2,995	3,365	1,209	2,415	2,031		
85		2,166	2,726	3,061	1,099	2,197	1,847	2,406	3,032	3,401	1,221	2,444	2,052		
86		2,189	2,757	3,093	1,113	2,224	1,868	2,432	3,067	3,437	1,236	2,470	2,076		
87		2,214	2,790	3,126	1,122	2,247	1,888	2,457	3,096	3,469	1,248	2,498	2,099		
88		2,236	2,815	3,152	1,132	2,269	1,908	2,483	3,127	3,501	1,259	2,523	2,120		
89		2,255	2,844	3,180	1,142	2,291	1,926	2,506	3,158	3,535	1,271	2,545	2,139		
90		2,276	2,868	3,205	1,152	2,312	1,942	2,528	3,185	3,564	1,281	2,569	2,158		
91		2,295	2,891	3,228	1,161	2,332	1,957	2,550	3,212	3,590	1,288	2,591	2,177		
92		2,311	2,913	3,252	1,168	2,348	1,973	2,570	3,238	3,612	1,298	2,609	2,195		
93		2,330	2,935	3,274	1,176	2,364	1,987	2,587	3,259	3,636	1,307	2,628	2,208		
94		2,343	2,953	3,291	1,183	2,380	2,001	2,603	3,279	3,656	1,314	2,643	2,221		
95		2,357	2,968	3,307	1,188	2,394	2,011	2,620	3,301	3,673	1,320	2,660	2,235		
96		2,371	2,987	3,324	1,194	2,408	2,023	2,635	3,320	3,694	1,327	2,675	2,246		
97		2,384	3,005	3,340	1,200	2,422	2,035	2,652	3,338	3,711	1,334	2,691	2,263		
98		2,399	3,021	3,357	1,207	2,436	2,047	2,666	3,360	3,731	1,339	2,705	2,275		
99		2,412	3,039	3,375	1,212	2,451	2,059	2,679	3,379	3,750	1,348	2,724	2,287		
Modal Factors:		Semi-Annual:					0.5200	Quarterly:					0.2650	Monthly:	0.0833

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

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

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

PREMIUM INFORMATION

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

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

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

DISCLOSURES

Use this outline to compare benefits and premium among policies.

HOUSEHOLD DISCOUNT

In order to be eligible for the Household discount under an American Continental Insurance Company Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently be covered by an American Continental Insurance Company Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (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.

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.

ACIMS01052TN

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

**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* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$166 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$166 (Part B Deductible) \$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 •Durable medical equipment •First \$166 of Medicare Approved amounts* •Remainder of Medicare Approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$166 (Part B Deductible) \$0

PLAN B

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

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

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

**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* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$166 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$166 (Part B Deductible) \$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 •Durable medical equipment •First \$166 of Medicare Approved amounts* •Remainder of Medicare Approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$166 (Part B Deductible) \$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 61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days	All but \$1288 All but \$322 a day All but \$644 a day \$0 \$0	\$1288 (Part A Deductible) \$322 a day \$644 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0 Up to \$161 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**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 Remainder of charges	 \$0 \$0	 \$0 80% to a lifetime maximum benefit of \$50,000	 \$250 20% and amounts over the \$50,000 lifetime maximum

HIGH DEDUCTIBLE PLAN F

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

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

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

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 61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days	All but \$1288 All but \$322 a day All but \$644 a day \$0 \$0	\$1288 (Part A Deductible) \$322 a day \$644 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- Approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0 Up to \$161 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

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

****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* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$166 (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$166 (Part B Deductible) 20%	\$0 \$0 \$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 61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days	All but \$1288 All but \$322 a day All but \$644 a day \$0 \$0	\$1288 (Part A Deductible) \$322 a day \$644 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0 Up to \$161 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness 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* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$166 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$166 (Part B Deductible) \$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 •Durable medical equipment •First \$166 of Medicare Approved amounts* •Remainder of Medicare Approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$166 (Part B Deductible) \$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

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

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

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First \$166 of Medicare-Approved amounts* 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* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$166 (Part B Deductible) \$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

