101 Continental Place
Brentwood, Tennessee 37027
800 264.4000
cont-life.com

OUTLINE OF COVERAGE

MEDICARE SUPPLEMENT INSURANCE
BENEFIT PLANS

Underwritten by
An Aetna Company American Continental Insurance Company

MICHIGAN

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 $[4140]; paid at 100% after limit reached	Out-of-pocket limit $[2070]; paid at 100% after limit reached		

*Plans 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 [$2070] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$2070]. 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.

ANNUAL ATTAINED AGE PREMIUMS

AMERICAN CONTINENTAL INSURANCE COMPANY

Medicare Supplement Policy
2010 Standardized Plan A

Attained	Preferred		Standard	
Age	Female	Male	Female	Male
0-64	N/A	N/A	N/A	N/A
65	944	1,086	1,049	1,207
66	944	1,086	1,049	1,207
67	944	1,086	1,049	1,207
68	985	1,131	1,094	1,257
69	1,028	1,183	1,142	1,313
70	1,069	1,229	1,187	1,366
71	1,111	1,277	1,233	1,418
72	1,148	1,321	1,276	1,467
73	1,184	1,363	1,316	1,514
74	1,220	1,401	1,355	1,557
75	1,250	1,437	1,388	1,597
76	1,279	1,470	1,420	1,634
77	1,306	1,500	1,452	1,669
78	1,330	1,531	1,480	1,700
79	1,355	1,557	1,505	1,730
80	1,377	1,583	1,529	1,758
81	1,396	1,605	1,551	1,783
82	1,414	1,626	1,571	1,807
83	1,434	1,648	1,592	1,832
84	1,451	1,668	1,612	1,853
85	1,467	1,688	1,630	1,876
86	1,484	1,706	1,649	1,896
87	1,499	1,724	1,667	1,915
88	1,515	1,742	1,683	1,936
89	1,529	1,758	1,699	1,954
90	1,543	1,775	1,715	1,970
91	1,555	1,789	1,728	1,988
92	1,567	1,802	1,742	2,003
93	1,578	1,815	1,753	2,017
94	1,589	1,826	1,765	2,030
95	1,598	1,837	1,776	2,041
96	1,607	1,849	1,785	2,054
97	1,616	1,859	1,796	2,066
98	1,625	1,870	1,806	2,078
99	1,636	1,881	1,818	2,090

Medicare Supplement Policy
2010 Standardized Plan B

Attained	Preferred		Standard	
Age	Female	Male	Female	Male
0-64	N/A	N/A	N/A	N/A
65	1,191	1,368	1,323	1,520
66	1,191	1,368	1,323	1,520
67	1,191	1,368	1,323	1,520
68	1,239	1,427	1,378	1,584
69	1,296	1,490	1,439	1,655
70	1,348	1,549	1,497	1,722
71	1,399	1,608	1,554	1,787
72	1,447	1,664	1,608	1,850
73	1,493	1,716	1,659	1,907
74	1,536	1,767	1,706	1,962
75	1,575	1,810	1,750	2,012
76	1,611	1,852	1,790	2,057
77	1,644	1,892	1,828	2,103
78	1,677	1,929	1,863	2,142
79	1,706	1,962	1,896	2,181
80	1,733	1,994	1,927	2,215
81	1,758	2,022	1,954	2,247
82	1,782	2,050	1,981	2,277
83	1,805	2,077	2,006	2,307
84	1,827	2,101	2,031	2,335
85	1,850	2,126	2,055	2,363
86	1,870	2,150	2,078	2,390
87	1,890	2,174	2,099	2,414
88	1,909	2,195	2,120	2,438
89	1,927	2,217	2,140	2,462
90	1,943	2,236	2,160	2,483
91	1,960	2,254	2,177	2,505
92	1,976	2,271	2,194	2,524
93	1,989	2,288	2,210	2,541
94	2,002	2,302	2,224	2,557
95	2,012	2,315	2,237	2,573
96	2,025	2,328	2,250	2,588
97	2,037	2,342	2,264	2,603
98	2,048	2,355	2,276	2,618
99	2,061	2,370	2,291	2,633

Modal Factors: Ann:1.0000 Semi: 0.5200 Qtrly: 0.2650 Mthly: 0.0833

The rates above do not include a one time $20 policy fee.

Area Factors:

Michigan

480-485	1.40
486-489, 492	1.15
Rest of State	1.00

ANNUAL ATTAINED AGE PREMIUMS

AMERICAN CONTINENTAL INSURANCE COMPANY

Medicare Supplement Policy
2010 Standardized Plan C

Attained	Preferred		Standard	
Age	Female	Male	Female	Male
0-64	2,230	2,564	2,478	2,849
65	1,338	1,540	1,488	1,711
66	1,338	1,540	1,488	1,711
67	1,338	1,540	1,488	1,711
68	1,398	1,607	1,553	1,787
69	1,455	1,674	1,617	1,859
70	1,510	1,736	1,678	1,930
71	1,563	1,797	1,737	1,997
72	1,612	1,854	1,791	2,060
73	1,658	1,906	1,842	2,119
74	1,701	1,957	1,890	2,174
75	1,742	2,003	1,935	2,226
76	1,778	2,045	1,976	2,273
77	1,816	2,089	2,019	2,321
78	1,850	2,127	2,055	2,363
79	1,880	2,163	2,090	2,403
80	1,904	2,191	2,116	2,434
81	1,929	2,218	2,143	2,464
82	1,952	2,245	2,169	2,494
83	1,975	2,271	2,194	2,523
84	1,996	2,296	2,219	2,551
85	2,017	2,320	2,241	2,578
86	2,038	2,343	2,264	2,603
87	2,057	2,364	2,284	2,627
88	2,075	2,386	2,306	2,651
89	2,093	2,407	2,326	2,674
90	2,111	2,427	2,345	2,696
91	2,128	2,446	2,363	2,718
92	2,143	2,464	2,381	2,738
93	2,156	2,480	2,397	2,756
94	2,170	2,496	2,411	2,773
95	2,182	2,509	2,424	2,787
96	2,193	2,523	2,437	2,803
97	2,206	2,536	2,451	2,818
98	2,218	2,551	2,464	2,834
99	2,230	2,564	2,478	2,849

Medicare Supplement Policy
2010 Standardized Plan F

Attained	Preferred		Standard	
Age	Female	Male	Female	Male
0-64	N/A	N/A	N/A	N/A
65	1,382	1,590	1,536	1,767
66	1,382	1,590	1,536	1,767
67	1,382	1,590	1,536	1,767
68	1,440	1,655	1,599	1,840
69	1,496	1,721	1,663	1,912
70	1,551	1,784	1,724	1,982
71	1,605	1,846	1,783	2,051
72	1,655	1,904	1,839	2,115
73	1,700	1,955	1,889	2,172
74	1,743	2,006	1,938	2,228
75	1,783	2,051	1,982	2,279
76	1,818	2,090	2,019	2,322
77	1,850	2,126	2,055	2,363
78	1,877	2,160	2,086	2,399
79	1,904	2,191	2,115	2,433
80	1,928	2,218	2,142	2,463
81	1,953	2,246	2,170	2,497
82	1,978	2,275	2,198	2,527
83	2,002	2,302	2,224	2,559
84	2,025	2,328	2,250	2,588
85	2,048	2,354	2,275	2,616
86	2,068	2,379	2,299	2,643
87	2,090	2,403	2,321	2,669
88	2,109	2,425	2,343	2,694
89	2,126	2,446	2,363	2,718
90	2,145	2,465	2,381	2,740
91	2,161	2,483	2,399	2,760
92	2,174	2,500	2,417	2,778
93	2,189	2,516	2,432	2,795
94	2,200	2,531	2,445	2,812
95	2,211	2,543	2,457	2,825
96	2,223	2,556	2,470	2,840
97	2,235	2,569	2,482	2,854
98	2,246	2,582	2,496	2,869
99	2,256	2,596	2,508	2,884

Modal Factors: Ann:1.0000 Semi: 0.5200 Qtrly: 0.2650 Mthly: 0.0833

The rates above do not include a one time $20 policy fee.

Area Factors:

Michigan

480-485	1.40
486-489, 492	1.15
Rest of State	1.00

ANNUAL ATTAINED AGE PREMIUMS

AMERICAN CONTINENTAL INSURANCE COMPANY

Medicare Supplement Policy
2010 Standardized Plan High F

Attained	Preferred		Standard	
Age	Female	Male	Female	Male
0-64	N/A	N/A	N/A	N/A
65	544	626	604	695
66	544	626	604	695
67	544	626	604	695
68	566	651	629	724
69	589	677	654	752
70	610	702	678	779
71	631	726	701	806
72	651	749	724	832
73	669	769	743	854
74	686	789	762	877
75	701	806	779	896
76	716	822	794	914
77	727	836	808	930
78	739	850	821	943
79	749	861	832	957
80	759	872	842	969
81	769	884	853	982
82	779	895	865	995
83	788	905	875	1,006
84	797	916	885	1,018
85	806	926	895	1,029
86	814	936	905	1,040
87	822	945	913	1,049
88	830	954	922	1,059
89	836	962	930	1,069
90	843	969	937	1,077
91	850	977	944	1,085
92	855	984	951	1,093
93	861	990	957	1,100
94	865	995	962	1,106
95	869	1,001	967	1,112
96	875	1,005	971	1,117
97	879	1,011	977	1,122
98	884	1,016	982	1,129
99	887	1,021	986	1,134

Medicare Supplement Policy
2010 Standardized Plan G

Attained	Preferred		Standard	
Age	Female	Male	Female	Male
0-64	N/A	N/A	N/A	N/A
65	1,211	1,391	1,345	1,546
66	1,211	1,391	1,345	1,546
67	1,211	1,391	1,345	1,546
68	1,261	1,450	1,401	1,611
69	1,318	1,516	1,464	1,684
70	1,370	1,576	1,522	1,751
71	1,422	1,635	1,580	1,817
72	1,472	1,692	1,635	1,880
73	1,518	1,746	1,687	1,940
74	1,562	1,796	1,735	1,995
75	1,601	1,841	1,779	2,046
76	1,638	1,884	1,820	2,093
77	1,673	1,924	1,859	2,138
78	1,706	1,961	1,895	2,179
79	1,735	1,995	1,928	2,217
80	1,763	2,028	1,959	2,253
81	1,788	2,057	1,987	2,286
82	1,813	2,084	2,014	2,317
83	1,836	2,111	2,040	2,346
84	1,859	2,138	2,066	2,375
85	1,881	2,163	2,090	2,403
86	1,902	2,187	2,113	2,430
87	1,922	2,210	2,136	2,456
88	1,941	2,232	2,157	2,480
89	1,959	2,254	2,177	2,504
90	1,976	2,273	2,197	2,526
91	1,994	2,292	2,215	2,547
92	2,008	2,309	2,231	2,566
93	2,022	2,326	2,247	2,584
94	2,036	2,341	2,262	2,601
95	2,048	2,354	2,274	2,616
96	2,059	2,368	2,288	2,632
97	2,072	2,382	2,301	2,647
98	2,084	2,396	2,315	2,662
99	2,096	2,410	2,329	2,678

Modal Factors: Ann:1.0000 Semi: 0.5200 Qtrly: 0.2650 Mthly: 0.0833

The rates above do not include a one time $20 policy fee.

Area Factors:

Michigan

480-485	1.40
486-489, 492	1.15
Rest of State	1.00

Annual Attained Age Premiums

AMERICAN CONTINENTAL INSURANCE COMPANY

Medicare Supplement Policy
2010 Standardized Plan N

Attained	Preferred		Standard	
Age	Female	Male	Female	Male
0-64	N/A	N/A	N/A	N/A
65	961	1,105	1,068	1,229
66	961	1,105	1,068	1,229
67	961	1,105	1,068	1,229
68	1,002	1,152	1,113	1,280
69	1,047	1,204	1,164	1,337
70	1,088	1,252	1,210	1,391
71	1,130	1,299	1,255	1,444
72	1,169	1,345	1,299	1,494
73	1,206	1,387	1,340	1,541
74	1,240	1,427	1,379	1,586
75	1,273	1,463	1,413	1,625
76	1,301	1,496	1,445	1,663
77	1,330	1,528	1,478	1,697
78	1,355	1,559	1,506	1,732
79	1,378	1,586	1,531	1,760
80	1,401	1,611	1,557	1,790
81	1,421	1,634	1,580	1,815
82	1,440	1,655	1,600	1,840
83	1,459	1,677	1,621	1,864
84	1,478	1,697	1,641	1,887
85	1,494	1,718	1,660	1,908
86	1,510	1,737	1,679	1,930
87	1,526	1,755	1,697	1,950
88	1,543	1,774	1,713	1,971
89	1,557	1,791	1,730	1,989
90	1,571	1,805	1,745	2,007
91	1,583	1,821	1,759	2,024
92	1,595	1,834	1,773	2,039
93	1,607	1,848	1,785	2,053
94	1,616	1,859	1,797	2,066
95	1,626	1,870	1,808	2,077
96	1,636	1,881	1,817	2,090
97	1,645	1,893	1,828	2,102
98	1,654	1,904	1,839	2,115
99	1,665	1,915	1,850	2,128

Modal Factors: Ann:1.0000 Semi: 0.5200 Qtrly: 0.2650 Mthly: 0.0833
The rates above do not include a one time $20 policy fee.

Area Factors:

Michigan

480-485	1.40
486-489, 492	1.15
Rest of State	1.00

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 annual 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 2368, Brentwood, Tennessee 37024. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do **NOT** cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

The policy may not cover all of your medical costs.

Neither American Continental Insurance Company nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare & You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely any questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

THE FOLLOWING CHARTS DESCRIBE PLANS A, B, F, HIGH DEDUCTIBLE F, G and N OFFERED BY AMERICAN CONTINENTAL INSURANCE COMPANY.

PLAN A

MEDICARE (PART A) – MEDICAL 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 [$1156]	$0	[$1156] (Part A Deductible)
61st thru 90th day	All but [$289] a day	[$289] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$578] a day	[$578] 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 [$144.50] a day	$0	Up to [$144.50] 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 [$140] 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 [$140] of Medicare-Approved amounts*	$0	$0	[$140] (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 [$140] of Medicare-Approved amounts*	$0	$0	[$140] (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 [$140] of Medicare Approved amounts*	$0	$0	[$140] (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 [$1156]	[$1156] (Part A Deductible)	$0
61st thru 90th day	All but [$289] a day	[$289] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$578] a day	[$578] 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 [$144.50] a day	$0	Up to [$144.50] 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 [$140] 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 [$140] of Medicare-Approved amounts*	$0	$0	[$140] (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 [$140] of Medicare-Approved amounts*	$0	$0	[$140] (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 [$140] of Medicare Approved amounts*	$0	$0	[$140] (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 [$1156]	[$1156] (Part A Deductible)	$0
61st thru 90th day	All but [$289] a day	[$289] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$578] a day	[$578] 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 [$144.50] a day	Up to [$144.50] 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 [$140] 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 [$140] of Medicare-Approved amounts*	$0	[$140] (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 [$140] of Medicare-Approved amounts*	$0	[$140] (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 [$140] of Medicare Approved amounts*	$0	[$140] (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 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 [$2070] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are [$2070]. 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 [$2070] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [$2070] DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1156]	[$1156] (Part A Deductible)	$0
61st thru 90th day	All but [$289] a day	[$289] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$578] a day	[$578] 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 [$144.50] a day	Up to [$144.50] 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 [$140] 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 [$2070] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are [$2070]. 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 [$2070] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [$2070] 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 [$140] of Medicare-Approved amounts*	$0	[$140] (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 [$140] of Medicare-Approved amounts*	$0	[$140] (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 [$2070] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [$2070] DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First [$140] of Medicare Approved amounts*	$0	[$140] (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2070] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2070] 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 [$1156]	[$1156] (Part A Deductible)	$0
61st thru 90th day	All but [$289] a day	[$289] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$578] a day	[$578] 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 [$144.50] a day	Up to [$144.50] 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 [$140] 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 [$140] of Medicare-Approved amounts*	$0	$0	[$140] (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 [$140] of Medicare-Approved amounts*	$0	$0	[$140] (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 [$140] of Medicare Approved amounts*	$0	$0	[$140] (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 [$1156]	[$1156] (Part A Deductible)	$0
61st thru 90th day	All but [$289] a day	[$289] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$578] a day	[$578] 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 [$144.50] a day	Up to [$144.50] 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 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 [$140] 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 [$140] of Medicare-Approved amounts*	$0	$0	[$140] (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 [$140] of Medicare-Approved amounts*	$0	$0	[$140] (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 [$140] of Medicare Approved amounts*	$0	$0	[$140] (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