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 either Plan "C" or Plan "F". Some plans may not be available in your state.

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

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 $[4800]; paid at 100% after limit reached	Out-of-pocket limit $[2400]; 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 [$2110] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$2110]. 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 Age	Preferred		Standard	
	Female	Male	Female	Male
0-64 (underwritten)	2,024	2,327	2,248	2,584
65	1,167	1,343	1,297	1,492
66	1,167	1,343	1,297	1,492
67	1,167	1,343	1,297	1,492
68	1,218	1,399	1,353	1,555
69	1,271	1,463	1,412	1,624
70	1,322	1,520	1,468	1,690
71	1,374	1,579	1,525	1,754
72	1,420	1,633	1,578	1,815
73	1,465	1,685	1,627	1,872
74	1,508	1,733	1,675	1,926
75	1,545	1,778	1,716	1,975
76	1,582	1,818	1,756	2,020
77	1,615	1,855	1,796	2,064
78	1,645	1,893	1,830	2,102
79	1,675	1,926	1,861	2,139
80	1,703	1,958	1,891	2,174
81	1,727	1,984	1,918	2,205
82	1,749	2,011	1,943	2,234
83	1,773	2,038	1,968	2,265
84	1,795	2,063	1,994	2,292
85	1,815	2,087	2,016	2,319
86	1,835	2,110	2,039	2,345
87	1,854	2,133	2,062	2,368
88	1,873	2,155	2,082	2,395
89	1,891	2,174	2,101	2,417
90	1,908	2,195	2,120	2,436
91	1,923	2,212	2,137	2,458
92	1,938	2,228	2,154	2,477
93	1,951	2,245	2,168	2,494
94	1,965	2,258	2,183	2,510
95	1,976	2,272	2,196	2,524
96	1,988	2,286	2,207	2,540
97	1,999	2,298	2,222	2,555
98	2,010	2,313	2,233	2,569
99	2,024	2,327	2,248	2,584

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

Medicare Supplement Policy
2010 Standardized Plan B

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
0-64 (underwritten)	N/A	N/A	N/A	N/A
65	1,325	1,522	1,473	1,692
66	1,325	1,522	1,473	1,692
67	1,325	1,522	1,473	1,692
68	1,379	1,588	1,534	1,763
69	1,443	1,659	1,602	1,842
70	1,501	1,724	1,665	1,916
71	1,557	1,789	1,730	1,989
72	1,610	1,852	1,789	2,059
73	1,662	1,910	1,847	2,123
74	1,710	1,966	1,900	2,184
75	1,753	2,015	1,947	2,239
76	1,794	2,062	1,992	2,290
77	1,830	2,105	2,035	2,342
78	1,866	2,147	2,074	2,384
79	1,900	2,184	2,110	2,427
80	1,929	2,219	2,144	2,466
81	1,957	2,250	2,175	2,502
82	1,983	2,282	2,205	2,534
83	2,009	2,312	2,232	2,567
84	2,034	2,338	2,261	2,599
85	2,059	2,366	2,286	2,629
86	2,082	2,392	2,313	2,661
87	2,104	2,419	2,336	2,686
88	2,124	2,443	2,361	2,714
89	2,144	2,467	2,382	2,740
90	2,162	2,488	2,404	2,763
91	2,181	2,508	2,423	2,788
92	2,200	2,527	2,442	2,809
93	2,214	2,546	2,459	2,828
94	2,228	2,562	2,476	2,846
95	2,240	2,577	2,490	2,864
96	2,255	2,591	2,505	2,880
97	2,266	2,607	2,520	2,897
98	2,280	2,621	2,533	2,914
99	2,295	2,638	2,549	2,931

Area Factors:

Kentucky

400-402, 410	1.10
Rest of State	0.90

ANNUAL ATTAINED AGE PREMIUMS

AMERICAN CONTINENTAL INSURANCE COMPANY

Medicare Supplement Policy
2010 Standardized Plan F

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
0-64 (underwritten)	2,790	3,210	3,102	3,566
65	1,710	1,966	1,900	2,185
66	1,710	1,966	1,900	2,185
67	1,710	1,966	1,900	2,185
68	1,781	2,047	1,978	2,275
69	1,850	2,128	2,056	2,364
70	1,918	2,206	2,132	2,451
71	1,984	2,283	2,205	2,537
72	2,047	2,355	2,274	2,616
73	2,102	2,418	2,336	2,686
74	2,156	2,480	2,397	2,755
75	2,205	2,537	2,451	2,819
76	2,248	2,584	2,496	2,872
77	2,287	2,629	2,541	2,921
78	2,321	2,671	2,580	2,966
79	2,355	2,709	2,616	3,008
80	2,384	2,742	2,649	3,046
81	2,416	2,778	2,684	3,088
82	2,446	2,813	2,718	3,125
83	2,475	2,847	2,751	3,164
84	2,505	2,879	2,783	3,200
85	2,532	2,912	2,813	3,235
86	2,558	2,942	2,843	3,269
87	2,584	2,972	2,870	3,300
88	2,608	2,999	2,897	3,332
89	2,629	3,025	2,921	3,361
90	2,652	3,049	2,945	3,388
91	2,672	3,071	2,967	3,413
92	2,689	3,092	2,989	3,435
93	2,707	3,112	3,007	3,457
94	2,720	3,130	3,024	3,477
95	2,735	3,145	3,039	3,494
96	2,750	3,161	3,054	3,513
97	2,763	3,177	3,070	3,530
98	2,778	3,193	3,087	3,548
99	2,790	3,210	3,102	3,566

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

Medicare Supplement Policy
2010 Standardized Plan High F

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
0-64 (underwritten)	N/A	N/A	N/A	N/A
65	672	774	747	860
66	672	774	747	860
67	672	774	747	860
68	700	805	778	895
69	728	837	809	930
70	755	868	838	964
71	780	898	867	997
72	805	926	895	1,028
73	827	951	919	1,056
74	848	976	942	1,084
75	867	997	964	1,109
76	885	1,017	982	1,130
77	899	1,034	1,000	1,150
78	914	1,050	1,015	1,166
79	926	1,065	1,028	1,183
80	938	1,078	1,042	1,199
81	951	1,093	1,055	1,215
82	962	1,107	1,070	1,230
83	974	1,119	1,082	1,244
84	985	1,133	1,094	1,259
85	996	1,145	1,107	1,272
86	1,006	1,158	1,118	1,286
87	1,017	1,169	1,129	1,297
88	1,026	1,180	1,140	1,310
89	1,034	1,189	1,150	1,322
90	1,043	1,199	1,159	1,332
91	1,050	1,207	1,167	1,342
92	1,058	1,217	1,177	1,352
93	1,065	1,224	1,183	1,360
94	1,070	1,231	1,189	1,367
95	1,075	1,238	1,196	1,375
96	1,082	1,243	1,201	1,381
97	1,088	1,250	1,207	1,388
98	1,093	1,256	1,215	1,396
99	1,097	1,262	1,220	1,402

Area Factors:

Kentucky

400-402, 410..... 1.10

Rest of State..... 0.90

ANNUAL ATTAINED AGE PREMIUMS

AMERICAN CONTINENTAL INSURANCE COMPANY

Medicare Supplement Policy
2010 Standardized Plan G

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
0-64 (underwritten)	N/A	N/A	N/A	N/A
65	1,347	1,549	1,497	1,721
66	1,347	1,549	1,497	1,721
67	1,347	1,549	1,497	1,721
68	1,403	1,614	1,560	1,794
69	1,466	1,686	1,629	1,875
70	1,524	1,754	1,694	1,948
71	1,583	1,820	1,760	2,022
72	1,638	1,884	1,820	2,092
73	1,690	1,943	1,877	2,159
74	1,738	1,999	1,931	2,221
75	1,782	2,049	1,980	2,277
76	1,823	2,097	2,026	2,329
77	1,862	2,142	2,069	2,380
78	1,898	2,183	2,109	2,425
79	1,931	2,221	2,145	2,467
80	1,962	2,257	2,180	2,507
81	1,990	2,290	2,211	2,544
82	2,018	2,320	2,242	2,579
83	2,044	2,350	2,271	2,611
84	2,068	2,380	2,299	2,644
85	2,095	2,407	2,326	2,675
86	2,117	2,435	2,352	2,705
87	2,139	2,460	2,378	2,734
88	2,161	2,485	2,401	2,761
89	2,180	2,508	2,423	2,787
90	2,200	2,530	2,445	2,811
91	2,219	2,551	2,466	2,836
92	2,236	2,571	2,484	2,857
93	2,250	2,589	2,502	2,877
94	2,266	2,605	2,518	2,896
95	2,279	2,620	2,531	2,912
96	2,292	2,636	2,546	2,929
97	2,306	2,651	2,562	2,946
98	2,319	2,667	2,577	2,963
99	2,333	2,683	2,592	2,982

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

Medicare Supplement Policy
2010 Standardized Plan N

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
0-64 (underwritten)	N/A	N/A	N/A	N/A
65	1,070	1,230	1,188	1,367
66	1,070	1,230	1,188	1,367
67	1,070	1,230	1,188	1,367
68	1,115	1,283	1,239	1,425
69	1,165	1,341	1,295	1,488
70	1,211	1,394	1,346	1,549
71	1,257	1,446	1,397	1,607
72	1,302	1,497	1,446	1,663
73	1,342	1,543	1,491	1,715
74	1,380	1,588	1,535	1,765
75	1,417	1,627	1,573	1,808
76	1,448	1,665	1,608	1,851
77	1,481	1,701	1,645	1,889
78	1,508	1,735	1,676	1,927
79	1,534	1,765	1,703	1,960
80	1,560	1,794	1,733	1,992
81	1,582	1,818	1,759	2,020
82	1,603	1,842	1,781	2,047
83	1,624	1,866	1,804	2,075
84	1,645	1,889	1,826	2,101
85	1,663	1,912	1,847	2,123
86	1,681	1,933	1,868	2,148
87	1,699	1,954	1,888	2,171
88	1,717	1,975	1,906	2,194
89	1,733	1,994	1,925	2,214
90	1,748	2,009	1,942	2,234
91	1,762	2,027	1,958	2,253
92	1,776	2,042	1,974	2,269
93	1,788	2,056	1,986	2,285
94	1,799	2,069	2,000	2,299
95	1,809	2,082	2,012	2,312
96	1,821	2,095	2,022	2,326
97	1,831	2,106	2,035	2,340
98	1,841	2,119	2,047	2,354
99	1,854	2,132	2,060	2,368

Area Factors:

Kentucky

400-402, 410..... 1.10

Rest of State..... 0.90

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) – 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 [$1184]	$0	[$1184] (Part A Deductible)
61st thru 90th day	All but [$296] a day	[$296] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$592] a day	[$592] 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 [$148] a day	$0	Up to [$148] 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 [$147] 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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare Approved amounts*	$0	$0	[$147] (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 [$1184]	[$1184] (Part A Deductible)	$0
61st thru 90th day	All but [$296] a day	[$296] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$592] a day	[$592] 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 [$148] a day	$0	Up to [$148] 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 [$147] 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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare Approved amounts*	$0	$0	[$147] (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 [$1184]	[$1184] (Part A Deductible)	$0
61st thru 90th day	All but [$296] a day	[$296] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$592] a day	[$592] 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 [$148] a day	Up to [$148] 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 [$147] 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 [$147] of Medicare-Approved amounts*	$0	[$147] (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 [$147] of Medicare-Approved amounts*	$0	[$147] (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 [$147] of Medicare Approved amounts*	$0	[$147] (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 [$2110] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are [$2110]. 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 [$2110] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [$2110] DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1184]	[$1184] (Part A Deductible)	$0
61st thru 90th day	All but [$296] a day	[$296] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$592] a day	[$592] 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 [$148] a day	Up to [$148] 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 [$147] 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 [$2110] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are [$2110]. 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 [$2110] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [$2110] 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 [$147] of Medicare-Approved amounts*	$0	[$147] (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 [$147] of Medicare-Approved amounts*	$0	[$147] (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 [$2110] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [$2110] DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment •First [$147] of Medicare Approved amounts*	$0	[$147] (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2110] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2110] 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 [$1184]	[$1184] (Part A Deductible)	$0
61st thru 90th day	All but [$296] a day	[$296] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$592] a day	[$592] 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 [$148] a day	Up to [$148] 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 [$147] 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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare Approved amounts*	$0	$0	[$147] (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 [$1184]	[$1184] (Part A Deductible)	$0
61st thru 90th day	All but [$296] a day	[$296] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$592] a day	[$592] 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 [$148] a day	Up to [$148] 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 [$147] 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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare Approved amounts*	$0	$0	[$147] (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