

**AMERICAN CONTINENTAL INSURANCE COMPANY**  
**Outline of Medicare Supplement Coverage - Cover Page: 1 of 2**  
Benefit Plan(s) A\*, B\*, D\*, F\*, J\*

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

**Basic Benefits for Plans A – J: 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. **Blood:** First three pints of blood each year .

A*	B*	C	D*	E	F*/F+	G	H	I	J* /J+
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Coinsurance.	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	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	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		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	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
				Preventive Care NOT covered by Medicare					Preventive Care NOT covered by Medicare

\*Plans A, B, D, F and J are offered by American Continental Insurance Company.

+Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year \$2,000 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are \$2,000. 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.

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Basic Benefits for Plans K and L include **similar** services as plans A – J, but cost-sharing for the basic benefits is a different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	\$4,620 Out of Pocket Annual Limit***	\$2,310 Out of Pocket Annual Limit***

\*\* Plans K and L provide for different cost-sharing for items and services than Plans A – J.

Once you reach the annual limit, the plan pays 100% of the Medicare co-payments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

\*\*\* The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

**AMERICAN CONTINENTAL INSURANCE COMPANY**

**Pennsylvania Individual Medicare Supplement Annual Rates Effective April 1, 2009 – Attained Age Rates – Rates Increase Each Year with Age**

Modal Factors: Ann: 1.0000; Semi: 0.5200; Qtrly: 0.2650; Mthly: 0.0833 Rates do not include one-time \$20 policy fee

Area Factors: 189-194 – 1.10; 150-154, 156 – 1.00; Rest of State – 0.90

For those applicants that are eligible for Open Enrollment or Guaranteed Issue, the Preferred Rate is Available

Attained Age	Standardized Plan A - AA1A			
	Preferred		Standard	
	Female	Male	Female	Male
0-64 (open enrollees)	994	1,143	N/A	N/A
65	994	1,143	1,105	1,271
66	994	1,143	1,105	1,271
67	994	1,143	1,105	1,271
68	1,036	1,192	1,151	1,324
69	1,083	1,245	1,202	1,383
70	1,126	1,295	1,251	1,439
71	1,169	1,344	1,298	1,493
72	1,209	1,390	1,343	1,545
73	1,247	1,434	1,386	1,594
74	1,283	1,475	1,426	1,639
75	1,316	1,513	1,462	1,681
76	1,346	1,548	1,495	1,719
77	1,374	1,580	1,528	1,757
78	1,401	1,612	1,557	1,790
79	1,426	1,639	1,583	1,822
80	1,449	1,666	1,610	1,851
81	1,470	1,689	1,633	1,877
82	1,489	1,713	1,655	1,903
83	1,509	1,735	1,676	1,928
84	1,527	1,756	1,697	1,951
85	1,545	1,777	1,717	1,974
86	1,562	1,797	1,736	1,996
87	1,579	1,815	1,755	2,017
88	1,595	1,834	1,772	2,038
89	1,610	1,851	1,789	2,057
90	1,624	1,868	1,805	2,075
91	1,637	1,883	1,820	2,093
92	1,650	1,897	1,833	2,108
93	1,661	1,911	1,846	2,123
94	1,673	1,923	1,857	2,137
95	1,682	1,934	1,869	2,149
96	1,692	1,946	1,880	2,162
97	1,702	1,957	1,891	2,175
98	1,712	1,969	1,902	2,187
99	1,722	1,980	1,913	2,200

Attained Age	Standardized Plan B - AA1B			
	Preferred		Standard	
	Female	Male	Female	Male
0-64 (open enrollees)	1,253	1,441	N/A	N/A
65	1,253	1,441	1,392	1,600
66	1,253	1,441	1,392	1,600
67	1,253	1,441	1,392	1,600
68	1,305	1,502	1,450	1,667
69	1,364	1,569	1,515	1,743
70	1,419	1,631	1,576	1,812
71	1,472	1,693	1,636	1,882
72	1,524	1,751	1,693	1,947
73	1,572	1,807	1,746	2,008
74	1,617	1,860	1,797	2,065
75	1,658	1,906	1,842	2,118
76	1,696	1,950	1,884	2,166
77	1,731	1,992	1,925	2,213
78	1,765	2,031	1,961	2,255
79	1,797	2,065	1,996	2,295
80	1,825	2,099	2,029	2,332
81	1,851	2,129	2,057	2,366
82	1,876	2,158	2,085	2,397
83	1,901	2,186	2,112	2,429
84	1,924	2,212	2,138	2,458
85	1,947	2,239	2,163	2,487
86	1,969	2,264	2,187	2,516
87	1,990	2,288	2,210	2,542
88	2,010	2,311	2,232	2,567
89	2,029	2,333	2,253	2,591
90	2,046	2,353	2,273	2,615
91	2,063	2,373	2,292	2,637
92	2,079	2,391	2,310	2,657
93	2,094	2,408	2,326	2,675
94	2,107	2,423	2,342	2,692
95	2,119	2,437	2,355	2,708
96	2,132	2,452	2,369	2,724
97	2,144	2,465	2,382	2,739
98	2,157	2,480	2,396	2,756
99	2,169	2,495	2,411	2,772

**AMERICAN CONTINENTAL INSURANCE COMPANY**

**Pennsylvania Individual Medicare Supplement Annual Rates Effective April 1, 2009 – Attained Age Rates – Rates Increase Each Year with Age**

Modal Factors: Ann: 1.0000; Semi: 0.5200; Qtrly: 0.2650; Mthly: 0.0833 Rates do not include one-time \$20 policy fee

Area Factors: 189-194 – 1.10; 150-154, 156 – 1.00; Rest of State – 0.90

For those applicants that are eligible for Open Enrollment or Guaranteed Issue, the Preferred Rate is available

Attained Age	Standardized Plan D - AA1D			
	Preferred		Standard	
	Female	Male	Female	Male
0-64 (open enrollees)	1,265	1,454	N/A	N/A
65	1,265	1,454	1,406	1,616
66	1,265	1,454	1,406	1,616
67	1,265	1,454	1,406	1,616
68	1,318	1,516	1,465	1,684
69	1,378	1,584	1,531	1,760
70	1,432	1,647	1,592	1,830
71	1,487	1,709	1,652	1,899
72	1,538	1,769	1,709	1,966
73	1,587	1,825	1,763	2,028
74	1,633	1,877	1,814	2,086
75	1,674	1,925	1,860	2,139
76	1,713	1,969	1,903	2,188
77	1,749	2,012	1,944	2,234
78	1,783	2,051	1,981	2,279
79	1,813	2,086	2,015	2,317
80	1,844	2,120	2,049	2,355
81	1,870	2,150	2,078	2,389
82	1,895	2,179	2,105	2,421
83	1,919	2,207	2,133	2,453
84	1,944	2,234	2,159	2,483
85	1,966	2,261	2,184	2,512
86	1,988	2,286	2,209	2,540
87	2,009	2,310	2,232	2,567
88	2,030	2,334	2,254	2,594
89	2,049	2,356	2,276	2,618
90	2,066	2,376	2,296	2,641
91	2,083	2,396	2,315	2,663
92	2,099	2,414	2,333	2,683
93	2,114	2,432	2,349	2,702
94	2,127	2,447	2,365	2,718
95	2,140	2,461	2,378	2,734
96	2,153	2,476	2,392	2,751
97	2,165	2,491	2,406	2,767
98	2,178	2,505	2,420	2,784
99	2,191	2,520	2,435	2,799

Attained Age	Standardized Plan F - AA1F			
	Preferred		Standard	
	Female	Male	Female	Male
0-64 (open enrollees)	1,420	1,632	N/A	N/A
65	1,420	1,632	1,576	1,811
66	1,420	1,632	1,576	1,811
67	1,420	1,632	1,576	1,811
68	1,483	1,703	1,645	1,891
69	1,542	1,772	1,713	1,968
70	1,600	1,839	1,777	2,041
71	1,656	1,903	1,839	2,113
72	1,707	1,962	1,896	2,179
73	1,756	2,017	1,950	2,241
74	1,802	2,071	2,000	2,300
75	1,844	2,119	2,048	2,353
76	1,883	2,163	2,091	2,402
77	1,923	2,209	2,136	2,454
78	1,957	2,249	2,174	2,498
79	1,990	2,287	2,210	2,540
80	2,016	2,316	2,239	2,573
81	2,041	2,346	2,267	2,605
82	2,065	2,374	2,294	2,637
83	2,090	2,401	2,321	2,667
84	2,113	2,428	2,346	2,696
85	2,135	2,453	2,370	2,724
86	2,156	2,477	2,393	2,751
87	2,176	2,500	2,416	2,776
88	2,195	2,523	2,438	2,801
89	2,213	2,544	2,458	2,826
90	2,232	2,566	2,479	2,850
91	2,250	2,586	2,499	2,872
92	2,266	2,604	2,517	2,893
93	2,281	2,622	2,534	2,912
94	2,295	2,638	2,548	2,930
95	2,307	2,651	2,562	2,945
96	2,319	2,666	2,577	2,961
97	2,332	2,681	2,590	2,978
98	2,345	2,695	2,605	2,994
99	2,358	2,710	2,619	3,010

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For those applicants that are eligible for Open Enrollment or Guaranteed Issue, the Preferred Rate is available

Attained Age	Standardized Plan J - AA1J			
	Preferred		Standard	
	Female	Male	Female	Male
0-64 (open enrollees)	1,481	1,703	N/A	N/A
65	1,481	1,703	1,645	1,890
66	1,481	1,703	1,645	1,890
67	1,481	1,703	1,645	1,890
68	1,547	1,777	1,717	1,973
69	1,609	1,849	1,787	2,052
70	1,670	1,918	1,853	2,130
71	1,728	1,985	1,918	2,204
72	1,781	2,047	1,978	2,273
73	1,831	2,105	2,034	2,338
74	1,880	2,160	2,087	2,399
75	1,924	2,211	2,136	2,455
76	1,964	2,256	2,181	2,506
77	2,006	2,305	2,228	2,560
78	2,042	2,347	2,267	2,606
79	2,075	2,386	2,306	2,650
80	2,104	2,417	2,336	2,684
81	2,130	2,447	2,365	2,717
82	2,155	2,476	2,394	2,751
83	2,180	2,505	2,421	2,783
84	2,204	2,533	2,447	2,813
85	2,227	2,559	2,472	2,842
86	2,249	2,584	2,496	2,870
87	2,269	2,608	2,521	2,896
88	2,289	2,632	2,544	2,922
89	2,310	2,654	2,565	2,947
90	2,329	2,677	2,587	2,974
91	2,348	2,698	2,607	2,996
92	2,364	2,716	2,626	3,018
93	2,379	2,735	2,643	3,038
94	2,395	2,752	2,659	3,056
95	2,407	2,766	2,673	3,073
96	2,420	2,782	2,688	3,089
97	2,433	2,797	2,702	3,107
98	2,446	2,812	2,717	3,123
99	2,460	2,827	2,732	3,140

## **PREMIUM INFORMATION**

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

Your premium will change on the first renewal date that coincides with or follows each Anniversary of the Effective Date. The new premium will be based upon your age at that time. Additionally, We reserve the right to revise the table of premium rates. If We make such a change of premium, We will provide to You at least thirty-one (31) days advance notice.

## **DISCLOSURES**

Use this outline to compare benefits and premiums 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 American Continental 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, 101 Continental Place, Brentwood, Tennessee 37027. If you send the policy back to us within thirty (30) days after you receive it, we will treat the policy as if it had never been issued and return all of 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**

This policy may not fully 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 and 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 all 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.

**PLAN A**  
**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
<b>HOSPITALIZATION*</b> 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 \$1,068 All but \$267 a day  All but \$534 a day  \$0 \$0	\$0 \$267 a day  \$534 a day  100% of Medicare Eligible Expense \$0	\$1,068 (Part A deductible) \$0  \$0  \$0** All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 \$133.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$133.50 a day All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 Pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

\*\*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 (Continued)**  
**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed \$135 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
<b>MEDICAL EXPENSES –</b> 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 tests, durable medical equipment. First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B deductible) \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$135 (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES -</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES -Medically necessary skilled care service and medical supplies -Durable medical equipment First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$135 (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
<b>HOSPITALIZATION*</b> 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 \$1,068 All but \$267 a day All but \$534 a day \$0 \$0	\$1,068 (Part A deductible) \$267 a day \$534 a day 100% of Medicare Eligible Expense \$0	\$0 \$0 \$0 \$0** All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 \$133.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$133.50 a day All Costs
<b>BLOOD</b> - First 3 pints - Additional Amounts	\$0 100%	3 Pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

\*\*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 B (Continued)**  
**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed \$135 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
<b>MEDICAL EXPENSES –</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as, Physician's services, inpatient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment.			
- First \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B deductible)
- Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amount)	\$0	\$0	All costs
<b>BLOOD</b>			
- First 3 pints	\$0	All Costs	\$0
- Next \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES			
-Medically necessary skilled care service and medical supplies	100%	\$0	\$0
-Durable medical equipment			
First \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**PLAN D**  
**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
<b>HOSPITALIZATION*</b> 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 \$1,068 All but \$267 a day All but \$534 a day \$0 \$0	\$1,068 (Part A deductible) \$267 a day \$534 a day 100% of Medicare Eligible Expense \$0	\$0 \$0 \$0 \$0** All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> - First 3 pints - Additional Amounts	\$0 100%	3 Pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

\*\*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 D (Continued)**  
**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed \$135 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
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as, Physician's services, inpatient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment. - First \$135 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B deductible) \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> - First 3 pints - Next \$135 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$135 (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b> -Medically necessary skilled care service and medical supplies -Durable medical equipment First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%   \$0 80%	\$0   \$0 20%	\$0   \$135 (Part B deductible) \$0
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**PLAN D (Continued)**  
**MEDICARE (PART A & B) - (CONTINUED)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE - (cont'd)</b> AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE  Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan. -Benefit for each visit  -Number of visits covered (must be received within 8 weeks of last Medicare Approved Visit.)  -Calendar year maximum	\$0  \$0  \$0	Actual Charges to \$40 a visit.  Up to number of Medicare Approved visits not to exceed 7 per week. \$1,600	Balance

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> Medically necessary emergency care service beginning during the first 60 days of each trip outside of 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 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
<b>HOSPITALIZATION*</b> 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 \$1,068 All but \$267 a day  All but \$534 a day  \$0  \$0	\$1,068 (Part A deductible) \$267 a day  \$534 a day  100% of Medicare Eligible Expense \$0	\$0 \$0  \$0  \$0**  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 Pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for out-patient drugs and in-patient respite care.	\$0	Balance

\*\*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 F (Continued) - MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed \$135 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
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as, Physician's services, inpatient and outpatient medical and surgical services, and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. - First \$135 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$135 (Part B deductible) Generally 20%	\$0 \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> - First 3 pints - Next \$135 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$135 (Part B deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b> -Medically necessary skilled care service and medical supplies -Durable medical equipment First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100%   \$0 80%	\$0   \$135 (Part B deductible) 20%	\$0   \$0 \$0
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**OTHER BENEFITS - NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> 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 J**  
**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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies. - First 60 days - 61 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 \$1,068 All but \$267 a day  All but \$534 a day  \$0  \$0	\$1,068 (Part A deductible) \$267 a day  \$534 a day  100% of Medicare Eligible Expense \$0	\$0 \$0  \$0  \$0**  All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 Pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for out-patient drugs and in-patient respite care.	\$0	Balance

\*\*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 J (Continued)**  
**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed \$135 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
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as, Physician's services, inpatient and outpatient medical and surgical services, and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$135 (Part B deductible) Generally 20%	\$0 \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	0%
<b>BLOOD</b> - First 3 pints - Next \$135 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$135 (Part B deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b> -Medically necessary skilled care service and medical supplies -Durable medical equipment First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$135 (Part B deductible) 20%	\$0 \$0 \$0
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**PLAN J (Continued) - MEDICARE (PART A & B) - (CONTINUED)**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE - (cont'd)</b> AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan. -Benefit for each visit.	\$0	Actual Charges to \$40 a visit.	Balance
-Number of visits covered (must be received within 8 weeks of last Medicare Approved Visit.)	\$0	Up to number of Medicare Approved visits not to exceed 7 per week.	
-Calendar year maximum	\$0	\$1,600	

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> 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.
<b>PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE*</b> Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare  First \$120 each calendar year Additional charges	\$0 \$0	\$120 \$0	\$0 All Costs

\*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.