



Genworth[®]
Financial

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

OUTLINE OF COVERAGE

MEDICARE SUPPLEMENT INSURANCE

Underwritten by
American Continental Insurance Company

ANNUAL ATTAINED AGE PREMIUMS

AMERICAN CONTINENTAL INSURANCE COMPANY

Medicare Supplement Policy
2010 Standardized Plan A

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
65	1,133	1,304	1,259	1,448
66	1,133	1,304	1,259	1,448
67	1,133	1,304	1,259	1,448
68	1,182	1,358	1,312	1,509
69	1,233	1,419	1,371	1,576
70	1,283	1,475	1,425	1,639
71	1,333	1,533	1,480	1,702
72	1,378	1,585	1,531	1,760
73	1,421	1,635	1,579	1,817
74	1,463	1,682	1,625	1,868
75	1,500	1,725	1,665	1,916
76	1,535	1,764	1,704	1,960
77	1,567	1,800	1,742	2,002
78	1,596	1,837	1,776	2,040
79	1,625	1,868	1,806	2,076
80	1,652	1,900	1,835	2,109
81	1,675	1,926	1,861	2,139
82	1,697	1,952	1,886	2,169
83	1,720	1,977	1,911	2,198
84	1,741	2,001	1,934	2,224
85	1,760	2,025	1,956	2,251
86	1,781	2,048	1,979	2,276
87	1,799	2,069	2,000	2,298
88	1,818	2,091	2,020	2,323
89	1,835	2,109	2,039	2,345
90	1,851	2,130	2,057	2,364
91	1,866	2,147	2,074	2,386
92	1,880	2,162	2,090	2,404
93	1,893	2,178	2,104	2,420
94	1,907	2,191	2,118	2,435
95	1,917	2,204	2,131	2,449
96	1,929	2,218	2,142	2,465
97	1,940	2,230	2,156	2,479
98	1,950	2,244	2,168	2,494
99	1,963	2,257	2,182	2,508

Medicare Supplement Policy
2010 Standardized Plan B

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
65	1,429	1,642	1,588	1,824
66	1,429	1,642	1,588	1,824
67	1,429	1,642	1,588	1,824
68	1,487	1,712	1,653	1,901
69	1,555	1,788	1,727	1,986
70	1,618	1,859	1,796	2,066
71	1,678	1,930	1,865	2,144
72	1,737	1,997	1,930	2,219
73	1,792	2,060	1,990	2,289
74	1,844	2,120	2,048	2,354
75	1,890	2,172	2,100	2,414
76	1,933	2,223	2,148	2,469
77	1,973	2,270	2,193	2,524
78	2,012	2,314	2,236	2,570
79	2,048	2,354	2,276	2,617
80	2,080	2,392	2,312	2,658
81	2,109	2,427	2,345	2,697
82	2,138	2,460	2,377	2,732
83	2,166	2,493	2,407	2,768
84	2,192	2,521	2,438	2,802
85	2,219	2,551	2,466	2,835
86	2,244	2,580	2,494	2,868
87	2,268	2,608	2,519	2,897
88	2,291	2,634	2,544	2,926
89	2,312	2,660	2,568	2,954
90	2,332	2,683	2,592	2,980
91	2,352	2,704	2,613	3,006
92	2,371	2,725	2,633	3,028
93	2,387	2,745	2,651	3,049
94	2,402	2,763	2,669	3,068
95	2,415	2,778	2,685	3,088
96	2,430	2,794	2,700	3,105
97	2,444	2,810	2,716	3,123
98	2,458	2,826	2,731	3,142
99	2,473	2,844	2,749	3,160

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

Area Factors:

<u>Ohio</u>	1.05
434-436, 440-445, 450-454.....	1.00
Rest of State.....	1.00

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

ANNUAL ATTAINED AGE PREMIUMS

AMERICAN CONTINENTAL INSURANCE COMPANY

Medicare Supplement Policy
2010 Standardized Plan F

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
65	1,659	1,908	1,844	2,120
66	1,659	1,908	1,844	2,120
67	1,659	1,908	1,844	2,120
68	1,728	1,986	1,919	2,208
69	1,795	2,065	1,996	2,294
70	1,861	2,141	2,068	2,378
71	1,926	2,215	2,139	2,461
72	1,986	2,285	2,206	2,538
73	2,040	2,346	2,267	2,606
74	2,092	2,407	2,325	2,673
75	2,139	2,461	2,378	2,735
76	2,182	2,508	2,422	2,786
77	2,219	2,551	2,466	2,835
78	2,253	2,592	2,503	2,878
79	2,285	2,629	2,538	2,919
80	2,313	2,661	2,570	2,956
81	2,344	2,696	2,604	2,996
82	2,374	2,730	2,637	3,033
83	2,402	2,763	2,669	3,070
84	2,430	2,794	2,700	3,105
85	2,457	2,825	2,730	3,140
86	2,482	2,854	2,758	3,172
87	2,508	2,884	2,785	3,202
88	2,530	2,910	2,811	3,232
89	2,551	2,935	2,835	3,262
90	2,574	2,958	2,858	3,288
91	2,593	2,980	2,879	3,312
92	2,609	3,000	2,901	3,334
93	2,627	3,020	2,918	3,354
94	2,640	3,037	2,934	3,374
95	2,654	3,052	2,948	3,390
96	2,668	3,067	2,964	3,408
97	2,682	3,082	2,979	3,425
98	2,696	3,099	2,995	3,443
99	2,708	3,115	3,010	3,460

Medicare Supplement Policy
2010 Standardized Plan High F

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
65	652	751	725	834
66	652	751	725	834
67	652	751	725	834
68	679	781	755	868
69	706	812	785	902
70	732	842	813	935
71	757	872	841	968
72	781	899	868	998
73	802	922	892	1,025
74	823	947	915	1,052
75	841	968	935	1,076
76	859	986	953	1,096
77	873	1,003	970	1,116
78	887	1,020	985	1,132
79	899	1,034	998	1,148
80	910	1,047	1,011	1,163
81	922	1,061	1,024	1,178
82	934	1,074	1,038	1,193
83	945	1,086	1,050	1,207
84	956	1,099	1,062	1,221
85	967	1,111	1,074	1,234
86	976	1,123	1,085	1,247
87	986	1,134	1,095	1,259
88	996	1,145	1,106	1,271
89	1,003	1,155	1,116	1,283
90	1,012	1,163	1,124	1,293
91	1,020	1,172	1,133	1,302
92	1,026	1,180	1,142	1,311
93	1,034	1,188	1,148	1,320
94	1,038	1,194	1,155	1,327
95	1,043	1,201	1,160	1,334
96	1,050	1,206	1,165	1,340
97	1,055	1,213	1,172	1,347
98	1,061	1,219	1,178	1,354
99	1,065	1,225	1,184	1,361

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

Area Factors:

Ohio
434-436, 440-445, 450-454..... 1.05
Rest of State..... 1.00

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

ANNUAL ATTAINED AGE PREMIUMS
AMERICAN CONTINENTAL INSURANCE COMPANY

Medicare Supplement Policy
2010 Standardized Plan G

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
65	1,453	1,670	1,614	1,855
66	1,453	1,670	1,614	1,855
67	1,453	1,670	1,614	1,855
68	1,513	1,740	1,682	1,933
69	1,581	1,819	1,757	2,021
70	1,644	1,891	1,826	2,101
71	1,706	1,962	1,896	2,181
72	1,766	2,030	1,962	2,256
73	1,822	2,095	2,024	2,327
74	1,874	2,156	2,082	2,394
75	1,921	2,210	2,135	2,455
76	1,966	2,260	2,184	2,511
77	2,008	2,309	2,231	2,565
78	2,047	2,353	2,274	2,615
79	2,082	2,394	2,313	2,660
80	2,116	2,433	2,351	2,703
81	2,146	2,469	2,385	2,743
82	2,175	2,501	2,417	2,780
83	2,203	2,534	2,448	2,816
84	2,230	2,565	2,479	2,850
85	2,257	2,595	2,508	2,884
86	2,282	2,624	2,536	2,916
87	2,306	2,652	2,563	2,947
88	2,330	2,678	2,589	2,976
89	2,351	2,704	2,613	3,005
90	2,372	2,728	2,636	3,032
91	2,392	2,751	2,658	3,056
92	2,409	2,771	2,677	3,079
93	2,427	2,791	2,697	3,101
94	2,443	2,809	2,714	3,121
95	2,457	2,825	2,729	3,140
96	2,471	2,841	2,745	3,158
97	2,486	2,859	2,762	3,176
98	2,500	2,875	2,778	3,195
99	2,515	2,892	2,795	3,214

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.

Medicare Supplement Policy
2010 Standardized Plan N

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
65	1,153	1,326	1,282	1,474
66	1,153	1,326	1,282	1,474
67	1,153	1,326	1,282	1,474
68	1,202	1,382	1,336	1,536
69	1,256	1,445	1,396	1,605
70	1,306	1,502	1,452	1,670
71	1,355	1,558	1,506	1,732
72	1,403	1,614	1,558	1,793
73	1,447	1,664	1,608	1,849
74	1,488	1,712	1,655	1,903
75	1,527	1,755	1,696	1,950
76	1,562	1,795	1,734	1,996
77	1,596	1,834	1,773	2,037
78	1,626	1,871	1,807	2,078
79	1,653	1,903	1,837	2,112
80	1,682	1,933	1,868	2,148
81	1,705	1,960	1,895	2,178
82	1,728	1,986	1,920	2,208
83	1,751	2,012	1,945	2,237
84	1,773	2,037	1,969	2,265
85	1,793	2,062	1,992	2,290
86	1,812	2,084	2,014	2,316
87	1,832	2,106	2,036	2,340
88	1,851	2,129	2,055	2,365
89	1,868	2,149	2,076	2,387
90	1,885	2,166	2,094	2,408
91	1,900	2,185	2,110	2,429
92	1,914	2,201	2,128	2,447
93	1,928	2,217	2,142	2,463
94	1,940	2,231	2,157	2,479
95	1,952	2,244	2,170	2,493
96	1,963	2,257	2,181	2,508
97	1,974	2,271	2,193	2,523
98	1,985	2,284	2,206	2,538
99	1,998	2,298	2,220	2,553

Area Factors:

Ohio
434-436, 440-445, 450-454..... 1.05
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 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 [\$1132] All but [\$283] a day All but [\$566] a day \$0 \$0	\$0 [\$283] a day [\$566] a day 100% of Medicare Eligible Expenses \$0	[\$1132] (Part A Deductible) \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$141.50] a day \$0	\$0 \$0 \$0	\$0 Up to [\$141.50] a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

PLAN A

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

*Once you have been billed [\$162] 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 [\$162] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	[\$162] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next [\$162] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$162] (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES ●Medically necessary skilled care services and medical supplies ●Durable medical equipment ●First [\$162]of Medicare Approved amounts* ●Remainder of Medicare Approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$162] (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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days 	<p>All but [\$1132]</p> <p>All but [\$283] a day</p> <p>All but [\$566] a day</p> <p>\$0</p> <p>\$0</p>	<p>[\$1132] (Part A Deductible)</p> <p>[\$283] a day</p> <p>[\$566] a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>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</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but [\$141.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to [\$141.50] a day</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/ coinsurance</p>	<p>\$0</p>

**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 [\$162] 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 [\$162] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	[\$162] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next [\$162] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$162] (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES ●Medically necessary skilled care services and medical supplies	100%	\$0	\$0
●Durable medical equipment ●First [\$162] of Medicare Approved amounts*	\$0	\$0	[\$162] (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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: <ul style="list-style-type: none"> •Additional 365 days •Beyond the Additional 365 days 	<p>All but [\$1132]</p> <p>All but [\$283] a day</p> <p>All but [\$566] a day</p> <p>\$0</p> <p>\$0</p>	<p>[\$1132] (Part A Deductible)</p> <p>[\$283] a day</p> <p>[\$566] a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>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</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but [\$141.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to [\$141.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/ coinsurance</p>	<p>\$0</p>

**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 [\$162] 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 [\$162] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	[\$162] (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	100%	\$0
BLOOD First 3 pints Next [\$162] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs [\$162] (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies •Durable medical equipment •First [\$162] of Medicare Approved amounts* •Remainder of Medicare Approved amounts	100% \$0 80%	\$0 [\$162] (Part B Deductible) 20%	\$0 \$0 \$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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 [\$2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are [\$2000]. 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 [\$2000] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [\$2000] DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after ●While using 60 lifetime reserve days ●Once lifetime reserve days are used: ●Additional 365 days ●Beyond the Additional 365 days	All but [\$1132] All but [\$283] a day All but [\$566] a day \$0 \$0	[\$1132] (Part A Deductible) [\$283] a day [\$566] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- Approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but [\$141.50] a day \$0	\$0 Up to [\$141.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0
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****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 [\$162] 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 [\$2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are [\$2000]. 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 [\$2000] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [\$2000] 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 [\$162] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	[\$162] (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	100%	\$0
BLOOD First 3 pints Next [\$162] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs [\$162] (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$2000] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [\$2000] DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES <ul style="list-style-type: none"> ●Medically necessary skilled care services and medical supplies ●Durable medical equipment ●First [\$162] of Medicare Approved amounts* ●Remainder of Medicare Approved amounts 	100%	\$0	\$0
	\$0	[\$162] (Part B Deductible)	\$0
	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$2000] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [\$2000] 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 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 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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days 	<p>All but [\$1132]</p> <p>All but [\$283] a day</p> <p>All but [\$566] a day</p> <p>\$0</p> <p>\$0</p>	<p>[\$1132] (Part A Deductible)</p> <p>[\$283] a day</p> <p>[\$566] a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>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</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but [\$141.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to [\$141.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness services</p>	<p>All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/ coinsurance</p>	<p>\$0</p>

**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 [\$162] 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 [\$162] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	[\$162] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	100%	\$0
BLOOD First 3 pints Next [\$162] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 [\$162] (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies •Durable medical equipment •First [\$162] of Medicare Approved amounts* •Remainder of Medicare Approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 [\$162] (Part B Deductible) \$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days 	<p>All but [\$1132]</p> <p>All but [\$283] a day</p> <p>All but [\$566] a day</p> <p>\$0</p> <p>\$0</p>	<p>[\$1132] (Part A Deductible)</p> <p>[\$283] a day</p> <p>[\$566] a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>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</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but [\$141.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to [\$141.50] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness services</p>	<p>All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare co-payment/ coinsurance</p>	<p>\$0</p>

**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 [\$162] 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
<p>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 [\$162] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts</p>	<p>\$0 Generally 80%</p>	<p>\$0 Balance, other than up to [\$20] per office visit and up to [\$50] per emergency room visit. The co-payment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.</p>	<p>[\$162] (Part B Deductible) Up to [\$20] per office visit and up to [\$50] per emergency room visit. The copayment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.</p>
<p>Part B Excess Charges (Above Medicare-Approved amounts)</p>	<p>\$0</p>	<p>0%</p>	<p>All costs</p>
<p>BLOOD First 3 pints Next [\$162] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts</p>	<p>\$0 \$0 80%</p>	<p>All costs \$0 20%</p>	<p>\$0 [\$162] (Part B Deductible) \$0</p>
<p>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</p>	<p>100%</p>	<p>\$0</p>	<p>\$0</p>

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES <ul style="list-style-type: none"> ●Medically necessary skilled care services and medical supplies ●Durable medical equipment ●First [\$162] of Medicare Approved amounts* ●Remainder of Medicare Approved amounts 	 100% \$0 80%	 \$0 \$0 20%	 \$0 [\$162] (Part B Deductible) \$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 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