Filing at a Glance

Company: American Continental Insurance Company

Product Name: Medicare Supplement	SERFF Tr Num: GEFA-126424755	State: Arkansas
TOI: MS08I Individual Medicare Supplement - Standard Plans 2010	SERFF Status: Closed-Approved-Closed	State Tr Num: 44706
Sub-TOI: MS08I.001 Plan A 2010	Co Tr Num: ACIMSP10A ET AL	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Stephanie Fowler
	Authors: Cindy Petty, Mary Ann Pyle	Disposition Date: 04/01/2010
	Date Submitted: 01/27/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date: 06/01/2010

State Filing Description:

General Information

Project Name: 2010 Medicare Supplement
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 04/01/2010

Deemer Date:
Submitted By: Mary Ann Pyle

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 04/01/2010
Created By: Mary Ann Pyle
Corresponding Filing Tracking Number:

Filing Description:

ATTACHED ARE NEW MEDICARE SUPPLEMENT POLICY FORMS. THESE FORMS WILL BE USED BY AMERICAN CONTINENTAL INSURANCE COMPANY TO PROVIDE COVERAGE TO INSUREDS WITH EFFECTIVE DATES OF JUNE 1, 2010 AND AFTER.

Company and Contact

Filing Contact Information

Mary Ann Pyle, Compliance Analyst
101 Continental Way
Brentwood, TN 37207

mary.pyle@genworth.com
615-370-9044 [Phone] 7652 [Ext]
615-373-0272 [FAX]

Filing Company Information

American Continental Insurance Company
101 Continental Place
Brentwood, TN 37027
(615) 377-1300 ext. [Phone]

CoCode: 12321
Group Code: 4011
Group Name:
FEIN Number: 20-2901054

State of Domicile: Tennessee
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$0.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Continental Insurance Company	$550.00	01/27/2010	33839171

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	04/01/2010	04/01/2010
Approved-Closed	Stephanie Fowler	03/10/2010	03/10/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Stephanie Fowler	03/31/2010	03/31/2010	Mary Ann Pyle	04/01/2010	04/01/2010
Pending Industry Response	Stephanie Fowler	03/10/2010	03/10/2010	Mary Ann Pyle	03/10/2010	03/10/2010

Disposition

Disposition Date: 04/01/2010

Implementation Date: 06/01/2010

Status: Approved-Closed

Comment: Thank you for your explaination regarding the policy fee references. Please see our original Disposition notice for more detailed approval information.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*GEFA-126424755*	*State:*	*Arkansas*
Filing Company:	*American Continental Insurance Company*	*State Tracking Number:*	*44706*
Company Tracking Number:	*ACIMSP10A ET AL*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*2010 Medicare Supplement /*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Accepted for Informational Purposes	No
Supporting Document *(revised)*	Outline of Coverage	Approved	Yes
Supporting Document	Outline of Coverage	Disapproved	Yes
Form *(revised)*	PLAN A POLICY	Approved	Yes
Form	PLAN A POLICY	Replaced	Yes
Form	PLAN B POLICY	Approved	Yes
Form	PLAN F POLICY	Approved	Yes
Form	PLAN HF POLICY	Approved	Yes
Form	PLAN G POLICY	Approved	Yes
Form	PLAN N POLICY	Approved	Yes
Form	REINSTATEMENT APPLICATION	Approved	Yes
Form	POLICY COVER	Approved	Yes
Form	POLICY AMENDMENT	Approved	Yes

Disposition

Disposition Date: 03/10/2010

Implementation Date: 06/01/2010

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*GEFA-126424755*	*State:*	*Arkansas*
Filing Company:	*American Continental Insurance Company*	*State Tracking Number:*	*44706*
Company Tracking Number:	*ACIMSP10A ET AL*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*2010 Medicare Supplement /*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Accepted for Informational Purposes	No
Supporting Document *(revised)*	Outline of Coverage	Approved	Yes
Supporting Document	Outline of Coverage	Disapproved	Yes
Form *(revised)*	PLAN A POLICY	Approved	Yes
Form	PLAN A POLICY	Replaced	Yes
Form	PLAN B POLICY	Approved	Yes
Form	PLAN F POLICY	Approved	Yes
Form	PLAN HF POLICY	Approved	Yes
Form	PLAN G POLICY	Approved	Yes
Form	PLAN N POLICY	Approved	Yes
Form	REINSTATEMENT APPLICATION	Approved	Yes
Form	POLICY COVER	Approved	Yes
Form	POLICY AMENDMENT	Approved	Yes

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	03/31/2010
Submitted Date	03/31/2010
Respond By Date	04/30/2010

Dear Mary Ann Pyle,

This will acknowledge receipt of the captioned filing. I apologize, but I missed the policy fee language; AR Rule and Regulation 27 s6(C) states "No Medicare supplement policy or certificate may include a policy fee or any other similar charge. Applicants cannot be required to pay any fee other than the approved premium".

Please revise this filing to comply.

Please feel free to contact me if you have questions.
Sincerely,
Stephanie Fowler

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	04/01/2010
Submitted Date	04/01/2010

Dear Stephanie Fowler,

Comments:

Response 1

Comments: We are aware that Arkansas does not allow a policy fee for Medicare supplement products. Our outline of coverage which is what the agents and policyholders would refer to regarding rates does not reflect that a policy fee should be added. There is a reference on the application to a policy fee however, our agents are aware there is no policy fee and either leave this line blank or indicate $0 on this line. The only reference to a policy fee in the filing is in the actuarial memo and we realize now that it was included in error. We will not be collecting a policy fee in Arkansas for the medicare supplement product.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Cindy Petty, Mary Ann Pyle

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	03/10/2010
Submitted Date	03/10/2010
Respond By Date	04/12/2010

Dear Mary Ann Pyle,

This will acknowledge receipt of the captioned filing.

Objection 1

- PLAN A POLICY, ACIMSP10A AR (Form)

Comment: Item 1 under "To Supplement Benefits under Part B of Medicare" - there is a typo in this paragraph.

Objection 2

- Outline of Coverage (Supporting Document)

Comment: Premium Information - Please remove the last three sentences of this section. These statements do not accurately reflect when the company can increase the rates and can be misleading to the insured.

Please feel free to contact me if you have questions.
Sincerely,
Stephanie Fowler

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	03/10/2010
Submitted Date	03/10/2010

Dear Stephanie Fowler,

Comments:

Response 1

Comments: We have corrected the typo on the Plan A policy.

Related Objection 1

Applies To:

- PLAN A POLICY, ACIMSP10A AR (Form)

Comment:

Item 1 under "To Supplement Benefits under Part B of Medicare" - there is a typo in this paragraph.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
PLAN A POLICY	ACIMSP10A AR		Policy/Contract/Fraternal Certificate	Initial			Plan A AR.pdf
Previous Version							
PLAN A POLICY	*ACIMSP10A AR*		*Policy/Contract/Fraternal Certificate*	*Initial*			Plan A AR.pdf

No Rate/Rule Schedule items changed.

Response 2

Comments: We have revised the premium information wording on the outline of coverage. We believe this will address the department's concerns.

Related Objection 1

Applies To:

- Outline of Coverage (Supporting Document)

Comment:

Premium Information - Please remove the last three sentences of this section. These statements do not accurately reflect when the company can increase the rates and can be misleading to the insured.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Outline of Coverage

SERFF Tracking Number:	*GEFA-126424755*	*State:*	*Arkansas*
Filing Company:	*American Continental Insurance Company*	*State Tracking Number:*	*44706*
Company Tracking Number:	*ACIMSP10A ET AL*		
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*Medicare Supplement*		
Project Name/Number:	*2010 Medicare Supplement /*		

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Cindy Petty, Mary Ann Pyle

Form Schedule

Lead Form Number: ACIMSP10A

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 03/10/2010	ACIMSP10A AR	Policy/Contract/Fraternal Certificate	PLAN A POLICY	Initial			Plan A AR.pdf
Approved 03/10/2010	ACIMSP10B AR	Policy/Contract/Fraternal Certificate	PLAN B POLICY	Initial			Plan B AR.pdf
Approved 03/10/2010	ACIMSP10F AR	Policy/Contract/Fraternal Certificate	PLAN F POLICY	Initial			Plan F AR.pdf
Approved 03/10/2010	ACIMSP10HF AR	Policy/Contract/Fraternal Certificate	PLAN HF POLICY	Initial			Plan HF AR.pdf
Approved 03/10/2010	ACIMSP10G AR	Policy/Contract/Fraternal Certificate	PLAN G POLICY	Initial			Plan G AR.pdf
Approved 03/10/2010	ACIMSP10N AR	Policy/Contract/Fraternal Certificate	PLAN N POLICY	Initial			Plan N AR.pdf
Approved 03/10/2010	ACI0315	Application/Enrollment Form	REINSTATEMENT APPLICATION	Initial			ACI0315 APPLICATION REINSTATEMENT.pdf
Approved	ACIMS001	Policy	POLICY COVER	Initial			ACIMS001.pd

03/10/2010		Jacket				f
Approved	PAF 12/09	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	POLICY AMENDMENT	Initial		ACIPAF 1209.pdf
03/10/2010						

AMERICAN CONTINENTAL INSURANCE COMPANY

HOME OFFICE
101 Continental Place
Brentwood, Tennessee 37027
Telephone: 1-800-264-4000

PREMIUMS ARE SUBJECT TO CHANGE
MEDICARE SUPPLEMENT POLICY – PLAN A

THIS POLICY PROVIDES BENEFITS FOR LOSS DUE TO INJURY OR SICKNESS AS HEREIN LIMITED AND PROVIDED.

Notice to buyer: This policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review all policy limitations.

In this policy the person insured is also called "you" or "your". American Continental Insurance Company is called "us", "we", "our", or "the company." The Definitions section defines other words and terms used in this policy.

In consideration of your payment of the required premiums for this policy, the company insures you against Loss caused by Injury or Sickness as herein limited and provided. Coverage is provided subject to the terms of this policy. The amount of the initial premium and the Effective Date of your policy are shown on the Policy Schedule. This policy is a legal contract between you and the company. READ YOUR POLICY CAREFULLY.

RIGHT TO EXAMINE POLICY FOR THIRTY (30) DAYS: You have 30 days after receipt of this policy to examine its provisions. During that 30-day period, if you are dissatisfied with the policy, it may be returned to the company at its Home Office, to any state office of the company or to the agent from whom it was purchased. Immediately upon such return, this policy shall be void from the beginning and any premium paid will be refunded.

GUARANTEED RENEWABLE: You have the right to renew this policy, for consecutive terms, by paying the required premium before the end of each grace period. You have the right to renew this policy regardless of changes in your physical, mental or health conditions.

PREMIUM AGREEMENT: On each annual anniversary of your Effective Date, premiums for this policy may be changed if there is any change in rates for this policy. Any change in premium will apply to all covered persons with your same policy type based on the issue state of your policy. For any premium change under this paragraph, we will give you at least 30 days advance notice in writing of such premium change.

CHANGE IN BENEFITS: Your benefits will change automatically to correspond with changes in Medicare.

IMPORTANT NOTICE

Please read the copy of your application attached to your policy. Omissions or misstatements in your application could cause a claim to be denied or your policy rescinded. If your policy is rescinded, it will be voided back to its Effective Date and you will have no insurance coverage under your policy. Carefully check your application and write to the Home Office within 10 days of the receipt of your policy if any information shown on it is not correct and complete or if any past medical history is left out of your application. Your application is part of your policy and your policy was issued on the basis that the answers to all questions and information shown on your application are correct and complete.

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American Continental Insurance Company

POLICY SCHEDULE

PLAN A

INSURED: [John Doe] AGE: [65] GENDER: [Male]

ADDRESS: [123 Main St.
Anytown, USA xxxxx]

POLICY NUMBER: [050-10-9999X] POLICY EFFECTIVE DATE: [01/01/10]

INITIAL PREMIUM: [$495.00] PREMIUM MODE: [ANNUAL]

MEDICARE (PART A) - HOSPITAL SERVICES

DAILY BENEFIT NOT COVERED BY MEDICARE:	THIS POLICY PAYS
FIRST 60 DAYS (Part-A Deductible per Benefit Period) .....;.....	0%
61ST TO 90TH DAY (Part A Coinsurance per Benefit Period).....	100%
91ST TO 150TH DAY (Part A Coinsurance for 60 Lifetime Inpatient Reserve Days)	100%
151ST TO 515TH DAY …….. (limited to a lifetime maximum of 365 days and payable at the same rate Medicare would have paid had Medicare Part A Hospital days not been exhausted)	100%
BLOOD TRANSFUSIONS (First three (3) Pints - Part A or B)	100%
REMAINDER OF MEDICARE APPROVED AMOUNT AFTER DEDUCTIBLE	20%

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

MEDICAL EXPENSES APPROVED BY MEDICARE:	
PART B DEDUCTIBLE AMOUNT OF MEDICARE APPROVED AMOUNTS	0%
REMAINDER OF MEDICARE APPROVED AMOUNTS	20%
PART-B EXCESS CHARGES ABOVE MEDICARE APPROVED AMOUNTS	0%

PARTS A & B

HOME HEALTH CARE, MEDICARE APPROVED SERVICES:	
DURABLE MEDICAL EQUIPMENT, PART B DEDUCTIBLE AMOUNT OF MEDICARE APPROVED AMOUNTS ……...	0%
REMAINDER OF MEDICARE APPROVED AMOUNTS AFTER DEDUCTIBLE....	20%

To Inquire About Your Coverage, or to Express a Concern, Call us Toll-Free at:
Policyholder Services: [1-800-XXX-XXXX]
Claims Customer Service: [1-800-XXX-XXXX]
or Write to Us at:
American Continental Insurance Company
P. O. Box 2368
Brentwood, Tennessee 37027-2368

DEFINITIONS

Shown below are the defined terms used in your policy. These terms are capitalized wherever they appear in the policy.

ACCIDENT means accidental bodily Injury or Injuries causing Loss under this policy. Such Injuries must be caused directly and independent of disease or bodily infirmity or any other cause.

BENEFIT PERIOD means a Benefit Period as defined by Medicare.

COMPANY OFFICER means the President or Secretary.

EFFECTIVE DATE means the date your policy coverage begins at 12:01 A.M. where you live. Your policy Effective Date is listed on the policy schedule page.

HOSPITAL means Hospital as defined by Medicare.

INPATIENT HOSPITAL DEDUCTIBLE means the initial amount of Hospital expenses you incur in a Medicare Benefit Period as a resident bed patient under Medicare Part A. Medicare establishes the amount of the Inpatient Hospital Deductible. Medicare does not pay this amount.

INJURY or INJURIES means bodily Injury caused by an Accident and resulting directly and independently of all other causes.

LIFETIME INPATIENT RESERVE DAYS means additional days that Medicare will pay for when you are confined to a Hospital for more than 90 days in a Benefit Period.
.

LOSS means the incurring of Medicare Eligible Expenses while this policy is in force.

MATERIAL INFORMATION means a condition or combination of conditions you were requested to disclose on the application were not disclosed and which, if disclosed, would have required a different premium or caused us to deny issuing your policy.

MEDICALLY NECESSARY means that the service or supply is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and must:

1. Be prescribed by a Physician;
2. Be consistent with the diagnosis and treatment of such Injury or Sickness;
3. Be in accordance with the generally accepted standards of medical practice; and
4. Not be solely for the convenience of the Insured or the Physician.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965 as then constituted or later amended.

MEDICARE COINSURANCE means the portion of charges covered but not reimbursed by Medicare, excluding the Medicare deductibles, for which you are responsible.

MEDICARE ELIGIBLE EXPENSES means health care expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

MEDICARE PART B DEDUCTIBLE means the amount you must pay each calendar year before benefits will be paid under Medicare Part B. Medicare establishes the amount of the Part B Deductible. Medicare does not pay this amount. A calendar year begins on January 1, and ends on December 31.

PHYSICIAN means a Physician as defined by Medicare.

PREMIUM DUE DATE means the month and day your policy's premium payment is due. The frequency of the Premium Due Date can vary depending on whether your premiums are paid on a monthly, quarterly, semiannual, or annual basis.

RESPITE CARE means treatment that meets Medicare's definition of respite care.

SICKNESS means illness or disease which first manifests itself after your policy's Effective Date and while your policy is in force.

SKILLED NURSING FACILITY means a Skilled Nursing Facility as defined by Medicare.

WRITTEN NOTIFICATION means written notice that you are currently receiving medical assistance or that your medical assistance received has terminated. This notification should include: Insured's name, policy number, copy of the document which indicates the date you became eligible for medical assistance or a copy of the document which indicates the date medical assistance terminated.

Notice must be given by or on behalf of the Insured or the beneficiary to the Home Office, Attn: Policyholders Service Department, or to any authorized agent of the company.

BENEFIT PROVISIONS

BASIC ("CORE") BENEFITS

TO SUPPLEMENT BENEFITS UNDER PART A OF MEDICARE:

1. We will pay all Part A Medicare Coinsurance for inpatient Hospital confinement to the extent not covered by Medicare from the 61st day through 90th day in any Medicare Benefit Period.

2. We will pay all Part A Medicare Coinsurance incurred for each Lifetime Inpatient Reserve Day to the extent not covered by Medicare. Lifetime Inpatient Reserve Days are nonrenewable and limited to 60 days during your lifetime.

3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the Lifetime Inpatient Reserve Days, we will pay one hundred percent of the Part A Medicare Eligible Expenses for inpatient Hospital confinement. Benefits are payable at the same rate Medicare would have paid had Medicare Part A Hospital days not been exhausted. Medicare exhaustion benefits are limited to a lifetime maximum of 365 days of inpatient Hospital confinement.

4. We will pay under Medicare Parts A and B the reasonable cost of the first three 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

5. We will pay the co-payment/coinsurance amount for all Part A Medicare Eligible Expenses for hospice care and Respite Care.

TO SUPPLEMENT BENEFITS UNDER PART B OF MEDICARE:

1. We will pay all of the Medicare Coinsurance amount, or in the case of hospital outpatient department services, paid under a prospective payment system, the copayment amount of Medicare Part B eligible Expenses regardless of Hospital confinement, subject to the Medicare Part B Deductible.

CHANGES IN MEDICARE COINSURANCE AND DEDUCTIBLES

Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

EXCLUSIONS

We will not pay for:

1. Loss incurred while your policy is not in force, except as provided in the Extension of Benefits section of your policy;
2. Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force;
3. That portion of any Loss incurred which is paid for by Medicare;
4. Services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take-home drugs and eye refractions;
5. Services for which a charge is not normally made in the absence of insurance;
6. Loss that is payable under any other Medicare supplement insurance policy or certificate; or
7. Loss that is payable under any other insurance which paid benefits for the same Loss on an expense incurred basis.

RECEIPT OF MEDICAL ASSISTANCE

Benefits and premium(s) under this policy shall be suspended upon your request for any period, (that may be provided by law), in which you have applied for and qualified for the receipt of medical assistance under Title XIX of the Social Security Act (Medicaid), but **only** if you notify us within ninety (90) days after the date you became entitled to such assistance.

If such suspension occurs and if you lose entitlement to such medical assistance, this policy shall be automatically reinstituted, effective as of the date of termination of such entitlement, if you provide Written Notification of loss of such entitlement within ninety (90) days after the date of such loss of entitlement and pay the premium attributable to this period, effective as of the date of termination of such entitlement.

Benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if you lose coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if you provide notice of loss of coverage within 90 days after the date of loss.

If such reinstitution occurs:

1. Your policy shall not provide for any waiting period with respect to treatment of Pre-Existing Conditions;

2. Your benefits provided under the reinstitution will be substantially the same as the benefits in effect before the date of such suspension; and

3. Your premium classification terms provided under the reinstitution will be at least as favorable to you as the premium terms that would have applied had this policy not been suspended.

POLICY TERMINATION

Your policy will terminate on the earliest of:

1. The date we receive your written request to cancel your policy (in which case the grace period will not apply);
2. The date your policy is replaced by another Medicare supplement or Medicare Select policy or by a Part C Medicare Advantage plan (in which case the grace period will not apply);
3. The Premium Due Date, if sufficient premium has not been paid before the end of the grace period; or
4. The date and time of your death.

In the event of cancellation or death, we will promptly return the unearned portion of any premium paid.

POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES: This policy, the application and any attached papers constitute the entire contract. No one has the authority to change this policy or to waive any of its provisions unless the change is approved in writing by a Company Officer. The approval must be written on or attached to this policy.

TIME LIMIT ON CERTAIN DEFENSES:

1. **Misstatement in your application:** We issued your policy based on information we were provided on your application. Any incorrect or omitted Material Information in your application may cause your policy to be rescinded (voided) back to the Effective Date of your policy or a claim to be denied.

2. **Time limit on certain defenses:**

   a. We may rescind (void) this policy or deny a claim for Loss incurred within 2 years from your policy Effective Date because of misstatement in your application.

   b. We may rescind (void) your policy or deny a claim for Loss incurred any time after 2 years from your policy's Effective Date only for fraudulent misstatement in your application.

GRACE PERIOD: A grace period of 31 days from your Premium Due Date will be allowed for late payment of premium. During such grace period, this policy will not lapse as long as you pay your full premium before the end of the grace period.

REINSTATEMENT: If any premium is not paid within the time your payment is due, a subsequent acceptance of premium by us or by any agent authorized by us to accept such premium, without requiring an application for reinstatement, shall reinstate your policy. However, if we or our agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, your policy will be reinstated only upon approval of the application by us or, lacking such approval, upon the 45th day following the date of the conditional receipt, unless we have previously notified you in writing of our disapproval of your application. If the application for reinstatement is disapproved, any premium received will be returned to you. If the application for reinstatement is approved, the reinstated policy will cover only Loss resulting from Injury or Sickness sustained after the Effective Date of reinstatement. In all other respects, you and the company shall have the same rights under this policy as were in effect before it lapsed, subject to the provisions of any rider which may be attached in connection with the reinstatement.

NOTICE OF CLAIM: Written notice of claim must be given to the company within twenty days after the beginning of any Loss covered by this policy. If notice cannot be given within that period, it must be given as soon as is reasonably possible. The notice will be considered sufficient if it identifies you and is given to the company at its Home Office or to any authorized agent of the company.

CLAIM FORMS: The company, after receiving notice of claim, will furnish to the claimant forms for filing proof of Loss. If forms are not furnished within 15 days after the giving of such notice, the claimant will be considered to have met the requirements of this policy for proof of Loss if the company is furnished proof of Loss as stated below.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this policy will be paid promptly after the company receives suitable written proof of Loss.

PROOF OF LOSS: Written proof of Loss must be sent to the company at its Home Office within 90 days after the date of Loss. Failure to furnish proof within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

PAYMENT OF CLAIMS: All benefits are payable to you unless we receive proof of an assignment of benefits to pay your health care provider. At your death, any accrued benefits unpaid, and which are not assigned, or unearned premium will be paid to your estate.

REFUND OF UNEARNED PREMIUM UPON DEATH OF INSURED: The company shall refund any premium paid for the period beyond the end of the policy month in which the death occurred. Unearned premium shall be paid in a lump sum to your estate no later than 30 days after receipt of proof of death is received by the company.

PHYSICAL EXAMINATIONS AND AUTOPSY: We, at our expense, shall have the right and opportunity to have a Physician examine you when and as often as we may reasonably require while a claim is pending under your policy, and to request an autopsy in case of death where it is not prohibited by law.

LEGAL ACTION: No action at law or in equity can be brought to recover on this policy until 60 days after written proof of Loss has been given to the company. No action can be brought after 3 years from the date written proof of Loss is required.

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its Effective Date, is in conflict with the statutes of the state in which you reside on such date is automatically changed to meet the minimum requirements of such statutes.

ASSIGNMENT: No assignment of interest under this policy will be binding upon the company unless notice of the assignment is received at the Home Office of the company. The company does not assume any responsibility for the assignment's validity.

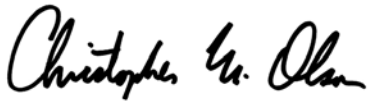
MISSTATEMENT OF AGE OR GENDER: If your age or gender has been misstated in your application for this policy, your premium will be adjusted based on your correct age or gender upon reasonable notice to you. If based on your true age this policy would not have been issued, we will be liable only for the refund of premiums paid for this policy.

UNPAID PREMIUMS: When benefits are paid for a claim under this policy, any premium due and unpaid may be deducted, at our option, from the benefits payable.

EXTENSION OF BENEFITS: Termination of your policy shall be without prejudice to any continuous Loss which commenced while your policy was in force, but the extension of benefits beyond the period that your policy was in force is: (a) subject to your continuous total disability; (b) limited to the duration of the Medicare Benefit Period or, if none is applicable, payment of the maximum benefits; and (c) limited to the covered Injury or Sickness causing the continuous loss beginning while your policy was in force. Receipt of Medicare Part D benefits will not be considered in determining a continuous Loss.

TERM OF COVERAGE: Your coverage starts on the Effective Date at 12:01 A.M. where you live. It ends at 12:01 A.M. where you live on the termination date as described in the Policy Termination section.

IN WITNESS WHEREOF, American Continental Insurance Company has caused this policy to be signed and attested by its authorized Company Officers.



President

Secretary

AMERICAN CONTINENTAL INSURANCE COMPANY

HOME OFFICE
101 Continental Place
Brentwood, Tennessee 37027
Telephone: 1-800-264-4000

MEDICARE SUPPLEMENT POLICY

THIS IS A PLAN "A"

If you need information or have any questions regarding your policy, please contact:

Policyholder Services
P. O. Box 2368
Brentwood, Tennessee 37024-1188
(800) 264-4000

AMERICAN CONTINENTAL INSURANCE COMPANY

HOME OFFICE
101 Continental Place
Brentwood, Tennessee 37027
Telephone: 1-800-264-4000

PREMIUMS ARE SUBJECT TO CHANGE
MEDICARE SUPPLEMENT POLICY – PLAN B

THIS POLICY PROVIDES BENEFITS FOR LOSS DUE TO INJURY OR SICKNESS AS HEREIN LIMITED AND PROVIDED.

Notice to buyer: This policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review all policy limitations.

In this policy the person insured is also called "you" or "your". American Continental Insurance Company is called "us", "we", "our", or "the company." The Definitions section defines other words and terms used in this policy.

In consideration of your payment of the required premiums for this policy, the company insures you against Loss caused by Injury or Sickness as herein limited and provided. Coverage is provided subject to the terms of this policy. The amount of the initial premium and the Effective Date of your policy are shown on the Policy Schedule. This policy is a legal contract between you and the company. READ YOUR POLICY CAREFULLY.

RIGHT TO EXAMINE POLICY FOR THIRTY (30) DAYS: You have 30 days after receipt of this policy to examine its provisions. During that 30-day period, if you are dissatisfied with the policy, it may be returned to the company at its Home Office, to any state office of the company or to the agent from whom it was purchased. Immediately upon such return, this policy shall be void from the beginning and any premium paid will be refunded.

GUARANTEED RENEWABLE: You have the right to renew this policy, for consecutive terms, by paying the required premium before the end of each grace period. You have the right to renew this policy regardless of changes in your physical, mental or health conditions.

PREMIUM AGREEMENT: On each annual anniversary of your Effective Date, premiums for this policy may be changed if there is any change in rates for this policy. Any change in premium will apply to all covered persons with your same policy type based on the issue state of your policy. For any premium change under this paragraph, we will give you at least 30 days advance notice in writing of such premium change.

CHANGE IN BENEFITS: Your benefits will change automatically to correspond with changes in Medicare.

IMPORTANT NOTICE

Please read the copy of your application attached to your policy. Omissions or misstatements in your application could cause a claim to be denied or your policy rescinded. If your policy is rescinded, it will be voided back to its Effective Date and you will have no insurance coverage under your policy. Carefully check your application and write to the Home Office within 10 days of the receipt of your policy if any information shown on it is not correct and complete or if any past medical history is left out of your application. Your application is part of your policy and your policy was issued on the basis that the answers to all questions and information shown on your application are correct and complete.

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American Continental Insurance Company

POLICY SCHEDULE

PLAN B

INSURED: [John Doe] AGE: [65] GENDER: [Male]

ADDRESS: [123 Main St.
Anytown, USA xxxxx]

POLICY NUMBER: [050-10-9999X] POLICY EFFECTIVE DATE: [01/01/10]

INITIAL PREMIUM: [$495.00] PREMIUM MODE: [ANNUAL]

MEDICARE (PART A) - HOSPITAL SERVICES

DAILY BENEFIT NOT COVERED BY MEDICARE:	THIS POLICY PAYS
FIRST 60 DAYS (Part-A Deductible per Benefit Period) .....;.....	100%
61ST TO 90TH DAY (Part A Coinsurance per Benefit Period).....	100%
91ST TO 150TH DAY (Part A Coinsurance for 60 Lifetime Inpatient Reserve Days)	100%
151ST TO 515TH DAY …….. (limited to a lifetime maximum of 365 days and payable at the same rate Medicare would have paid had Medicare Part A Hospital days not been exhausted)	100%
BLOOD TRANSFUSIONS (First three (3) Pints - Part A or B)	100%
REMAINDER OF MEDICARE APPROVED AMOUNT AFTER DEDUCTIBLE	20%

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

MEDICAL EXPENSES APPROVED BY MEDICARE:	
PART B DEDUCTIBLE AMOUNT OF MEDICARE APPROVED AMOUNTS	0%
REMAINDER OF MEDICARE APPROVED AMOUNTS	20%
PART-B EXCESS CHARGES ABOVE MEDICARE APPROVED AMOUNTS	0%

PARTS A & B

HOME HEALTH CARE, MEDICARE APPROVED SERVICES:	
DURABLE MEDICAL EQUIPMENT, PART B DEDUCTIBLE AMOUNT OF MEDICARE APPROVED AMOUNTS ……...	0%
REMAINDER OF MEDICARE APPROVED AMOUNTS AFTER DEDUCTIBLE....	20%

To Inquire About Your Coverage, or to Express a Concern, Call us Toll-Free at:
Policyholder Services: [1-800-XXX-XXXX]
Claims Customer Service: [1-800-XXX-XXXX]
or Write to Us at:
American Continental Insurance Company
P. O. Box 2368
Brentwood, Tennessee 37027-2368

DEFINITIONS

Shown below are the defined terms used in your policy. These terms are capitalized wherever they appear in the policy.

ACCIDENT means accidental bodily Injury or Injuries causing Loss under this policy. Such Injuries must be caused directly and independent of disease or bodily infirmity or any other cause.

BENEFIT PERIOD means a Benefit Period as defined by Medicare.

COMPANY OFFICER means the President or Secretary.

EFFECTIVE DATE means the date your policy coverage begins at 12:01 A.M. where you live. Your policy Effective Date is listed on the policy schedule page.

HOSPITAL means Hospital as defined by Medicare.

INPATIENT HOSPITAL DEDUCTIBLE means the initial amount of Hospital expenses you incur in a Medicare Benefit Period as a resident bed patient under Medicare Part A. Medicare establishes the amount of the Inpatient Hospital Deductible. Medicare does not pay this amount.

INJURY or INJURIES means bodily Injury caused by an Accident and resulting directly and independently of all other causes.

LIFETIME INPATIENT RESERVE DAYS means additional days that Medicare will pay for when you are confined to a Hospital for more than 90 days in a Benefit Period.
.

LOSS means the incurring of Medicare Eligible Expenses while this policy is in force.

MATERIAL INFORMATION means a condition or combination of conditions you were requested to disclose on the application were not disclosed and which, if disclosed, would have required a different premium or caused us to deny issuing your policy.

MEDICALLY NECESSARY means that the service or supply is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and must:

1. Be prescribed by a Physician;
2. Be consistent with the diagnosis and treatment of such Injury or Sickness;
3. Be in accordance with the generally accepted standards of medical practice; and
4. Not be solely for the convenience of the Insured or the Physician.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965 as then constituted or later amended.

MEDICARE COINSURANCE means the portion of charges covered but not reimbursed by Medicare, excluding the Medicare deductibles, for which you are responsible.

MEDICARE ELIGIBLE EXPENSES means health care expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

MEDICARE PART B DEDUCTIBLE means the amount you must pay each calendar year before benefits will be paid under Medicare Part B. Medicare establishes the amount of the Part B Deductible. Medicare does not pay this amount. A calendar year begins on January 1, and ends on December 31.

PHYSICIAN means a Physician as defined by Medicare.

PREMIUM DUE DATE means the month and day your policy's premium payment is due. The frequency of the Premium Due Date can vary depending on whether your premiums are paid on a monthly, quarterly, semiannual, or annual basis.

RESPITE CARE means treatment that meets Medicare's definition of respite care.

SICKNESS means illness or disease which first manifests itself after your policy's Effective Date and while your policy is in force.

SKILLED NURSING FACILITY means a Skilled Nursing Facility as defined by Medicare.

WRITTEN NOTIFICATION means written notice that you are currently receiving medical assistance or that your medical assistance received has terminated. This notification should include: Insured's name, policy number, copy of the document which indicates the date you became eligible for medical assistance or a copy of the document which indicates the date medical assistance terminated.

Notice must be given by or on behalf of the Insured or the beneficiary to the Home Office, Attn: Policyholders Service Department, or to any authorized agent of the company.

BENEFIT PROVISIONS

BASIC ("CORE") BENEFITS

TO SUPPLEMENT BENEFITS UNDER PART A OF MEDICARE:

1. We will pay all Part A Medicare Coinsurance for inpatient Hospital confinement to the extent not covered by Medicare from the 61st day through 90th day in any Medicare Benefit Period.

2. We will pay all Part A Medicare Coinsurance incurred for each Lifetime Inpatient Reserve Day to the extent not covered by Medicare. Lifetime Inpatient Reserve Days are nonrenewable and limited to 60 days during your lifetime.

3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the Lifetime Inpatient Reserve Days, we will pay one hundred percent of the Part A Medicare Eligible Expenses for inpatient Hospital confinement. Benefits are payable at the same rate Medicare would have paid had Medicare Part A Hospital days not been exhausted. Medicare exhaustion benefits are limited to a lifetime maximum of 365 days of inpatient Hospital confinement.

4. We will pay under Medicare Parts A and B the reasonable cost of the first three 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

5. We will pay the co-payment/coinsurance amount for all Part A Medicare Eligible Expenses for hospice care and Respite Care.

TO SUPPLEMENT BENEFITS UNDER PART B OF MEDICARE:

1. We will pay all of the Medicare Coinsurance amount, or in the case of hospital outpatient department services, paid under a prospective payment system, the copayment amount of Medicare Part B eligible Expenses regardless of Hospital confinement, subject to the Medicare Part B Deductible.

ADDITIONAL BENEFITS

TO SUPPLEMENT BENEFITS UNDER PART A OF MEDICARE:

1. We will pay one hundred percent (100%) of the Medicare Part A Inpatient Hospital Deductible amount per Benefit Period.

CHANGES IN MEDICARE COINSURANCE AND DEDUCTIBLES

Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

EXCLUSIONS

We will not pay for:

1. Loss incurred while your policy is not in force, except as provided in the Extension of Benefits section of your policy;
2. Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force;
3. That portion of any Loss incurred which is paid for by Medicare;
4. Services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take-home drugs and eye refractions;
5. Services for which a charge is not normally made in the absence of insurance;
6. Loss that is payable under any other Medicare supplement insurance policy or certificate; or
7. Loss that is payable under any other insurance which paid benefits for the same Loss on an expense incurred basis.

RECEIPT OF MEDICAL ASSISTANCE

Benefits and premium(s) under this policy shall be suspended upon your request for any period, (that may be provided by law), in which you have applied for and qualified for the receipt of medical assistance under Title XIX of the Social Security Act (Medicaid), but **only** if you notify us within ninety (90) days after the date you became entitled to such assistance.

If such suspension occurs and if you lose entitlement to such medical assistance, this policy shall be automatically reinstituted, effective as of the date of termination of such entitlement, if you provide Written Notification of loss of such entitlement within ninety (90) days after the date of such loss of entitlement and pay the premium attributable to this period, effective as of the date of termination of such entitlement.

Benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if you lose coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if you provide notice of loss of coverage within 90 days after the date of loss.

If such reinstitution occurs:

1. Your policy shall not provide for any waiting period with respect to treatment of Pre-Existing Conditions;

2. Your benefits provided under the reinstitution will be substantially the same as the benefits in effect before the date of such suspension; and

3. Your premium classification terms provided under the reinstitution will be at least as favorable to you as the premium terms that would have applied had this policy not been suspended.

POLICY TERMINATION

Your policy will terminate on the earliest of:

1. The date we receive your written request to cancel your policy (in which case the grace period will not apply);
2. The date your policy is replaced by another Medicare supplement or Medicare Select policy or by a Part C Medicare Advantage plan (in which case the grace period will not apply);
3. The Premium Due Date, if sufficient premium has not been paid before the end of the grace period; or
4. The date and time of your death.

In the event of cancellation or death, we will promptly return the unearned portion of any premium paid.

POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES: This policy, the application and any attached papers constitute the entire contract. No one has the authority to change this policy or to waive any of its provisions unless the change is approved in writing by a Company Officer. The approval must be written on or attached to this policy.

TIME LIMIT ON CERTAIN DEFENSES:

1. **Misstatement in your application:** We issued your policy based on information we were provided on your application. Any incorrect or omitted Material Information in your application may cause your policy to be rescinded (voided) back to the Effective Date of your policy or a claim to be denied.

2. **Time limit on certain defenses:**

   a. We may rescind (void) this policy or deny a claim for Loss incurred within 2 years from your policy Effective Date because of misstatement in your application.

   b. We may rescind (void) your policy or deny a claim for Loss incurred any time after 2 years from your policy's Effective Date only for fraudulent misstatement in your application.

GRACE PERIOD: A grace period of 31 days from your Premium Due Date will be allowed for late payment of premium. During such grace period, this policy will not lapse as long as you pay your full premium before the end of the grace period.

REINSTATEMENT: If any premium is not paid within the time your payment is due, a subsequent acceptance of premium by us or by any agent authorized by us to accept such premium, without requiring an application for reinstatement, shall reinstate your policy. However, if we or our agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, your policy will be reinstated only upon approval of the application by us or, lacking such approval, upon the 45th day following the date of the conditional receipt, unless we have previously notified you in writing of our disapproval of your application. If the application for reinstatement is disapproved, any premium received will be returned to you. If the application for reinstatement is approved, the reinstated policy will cover only Loss resulting from Injury or Sickness sustained after the Effective Date of reinstatement. In all other respects, you and the company shall have the same rights under this policy as were in effect before it lapsed, subject to the provisions of any rider which may be attached in connection with the reinstatement.

NOTICE OF CLAIM: Written notice of claim must be given to the company within twenty days after the beginning of any Loss covered by this policy. If notice cannot be given within that period, it must be given as soon as is reasonably possible. The notice will be considered sufficient if it identifies you and is given to the company at its Home Office or to any authorized agent of the company.

CLAIM FORMS: The company, after receiving notice of claim, will furnish to the claimant forms for filing proof of Loss. If forms are not furnished within 15 days after the giving of such notice, the claimant will be considered to have met the requirements of this policy for proof of Loss if the company is furnished proof of Loss as stated below.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this policy will be paid promptly after the company receives suitable written proof of Loss.

PROOF OF LOSS: Written proof of Loss must be sent to the company at its Home Office within 90 days after the date of Loss. Failure to furnish proof within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

PAYMENT OF CLAIMS: All benefits are payable to you unless we receive proof of an assignment of benefits to pay your health care provider. At your death, any accrued benefits unpaid, and which are not assigned, or unearned premium will be paid to your estate.

REFUND OF UNEARNED PREMIUM UPON DEATH OF INSURED: The company shall refund any premium paid for the period beyond the end of the policy month in which the death occurred. Unearned premium shall be paid in a lump sum to your estate no later than 30 days after receipt of proof of death is received by the company.

PHYSICAL EXAMINATIONS AND AUTOPSY: We, at our expense, shall have the right and opportunity to have a Physician examine you when and as often as we may reasonably require while a claim is pending under your policy, and to request an autopsy in case of death where it is not prohibited by law.

LEGAL ACTION: No action at law or in equity can be brought to recover on this policy until 60 days after written proof of Loss has been given to the company. No action can be brought after 3 years from the date written proof of Loss is required.

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its Effective Date, is in conflict with the statutes of the state in which you reside on such date is automatically changed to meet the minimum requirements of such statutes.

ASSIGNMENT: No assignment of interest under this policy will be binding upon the company unless notice of the assignment is received at the Home Office of the company. The company does not assume any responsibility for the assignment's validity.

MISSTATEMENT OF AGE OR GENDER: If your age or gender has been misstated in your application for this policy, your premium will be adjusted based on your correct age or gender upon reasonable notice to you. If based on your true age this policy would not have been issued, we will be liable only for the refund of premiums paid for this policy.

UNPAID PREMIUMS: When benefits are paid for a claim under this policy, any premium due and unpaid may be deducted, at our option, from the benefits payable.

EXTENSION OF BENEFITS: Termination of your policy shall be without prejudice to any continuous Loss which commenced while your policy was in force, but the extension of benefits beyond the period that your policy was in force is: (a) subject to your continuous total disability; (b) limited to the duration of the Medicare Benefit Period or, if none is applicable, payment of the maximum benefits; and (c) limited to the covered Injury or Sickness causing the continuous loss beginning while your policy was in force. Receipt of Medicare Part D benefits will not be considered in determining a continuous Loss.

TERM OF COVERAGE: Your coverage starts on the Effective Date at 12:01 A.M. where you live. It ends at 12:01 A.M. where you live on the termination date as described in the Policy Termination section.

IN WITNESS WHEREOF, American Continental Insurance Company has caused this policy to be signed and attested by its authorized Company Officers.

President

Secretary

AMERICAN CONTINENTAL INSURANCE COMPANY

HOME OFFICE
101 Continental Place
Brentwood, Tennessee 37027
Telephone: 1-800-264-4000

MEDICARE SUPPLEMENT POLICY

THIS IS A PLAN "B"

If you need information or have any questions regarding your policy, please contact:

Policyholder Services
P. O. Box 2368
Brentwood, Tennessee 37024-1188
(800) 264-4000

AMERICAN CONTINENTAL INSURANCE COMPANY

HOME OFFICE
101 Continental Place
Brentwood, Tennessee 37027
Telephone: 1-800-264-4000

PREMIUMS ARE SUBJECT TO CHANGE
MEDICARE SUPPLEMENT POLICY – PLAN F

THIS POLICY PROVIDES BENEFITS FOR LOSS DUE TO INJURY OR SICKNESS AS HEREIN LIMITED AND PROVIDED.

Notice to buyer: This policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review all policy limitations.

In this policy the person insured is also called "you" or "your". American Continental Insurance Company is called "us", "we", "our", or "the company." The Definitions section defines other words and terms used in this policy.

In consideration of your payment of the required premiums for this policy, the company insures you against Loss caused by Injury or Sickness as herein limited and provided. Coverage is provided subject to the terms of this policy. The amount of the initial premium and the Effective Date of your policy are shown on the Policy Schedule. This policy is a legal contract between you and the company. READ YOUR POLICY CAREFULLY.

RIGHT TO EXAMINE POLICY FOR THIRTY (30) DAYS: You have 30 days after receipt of this policy to examine its provisions. During that 30-day period, if you are dissatisfied with the policy, it may be returned to the company at its Home Office, to any state office of the company or to the agent from whom it was purchased. Immediately upon such return, this policy shall be void from the beginning and any premium paid will be refunded.

GUARANTEED RENEWABLE: You have the right to renew this policy, for consecutive terms, by paying the required premium before the end of each grace period. You have the right to renew this policy regardless of changes in your physical, mental or health conditions.

PREMIUM AGREEMENT: On each annual anniversary of your Effective Date, premiums for this policy may be changed if there is any change in rates for this policy. Any change in premium will apply to all covered persons with your same policy type based on the issue state of your policy. For any premium change under this paragraph, we will give you at least 30 days advance notice in writing of such premium change.

CHANGE IN BENEFITS: Your benefits will change automatically to correspond with changes in Medicare.

IMPORTANT NOTICE

Please read the copy of your application attached to your policy. Omissions or misstatements in your application could cause a claim to be denied or your policy rescinded. If your policy is rescinded, it will be voided back to its Effective Date and you will have no insurance coverage under your policy. Carefully check your application and write to the Home Office within 10 days of the receipt of your policy if any information shown on it is not correct and complete or if any past medical history is left out of your application. Your application is part of your policy and your policy was issued on the basis that the answers to all questions and information shown on your application are correct and complete.

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American Continental Insurance Company
POLICY SCHEDULE

PLAN F

INSURED: [John Doe] AGE: [65] GENDER: [Male]

ADDRESS: [123 Main St.
Anytown, USA xxxxx]

POLICY NUMBER: [050-10-9999X] POLICY EFFECTIVE DATE: [01/01/10]

INITIAL PREMIUM: [$495.00] PREMIUM MODE: [ANNUAL]

MEDICARE (PART A) - HOSPITAL SERVICES

DAILY BENEFIT NOT COVERED BY MEDICARE:	THIS POLICY PAYS
FIRST 60 DAYS (Part-A Deductible per Benefit Period) .....;.....	100%
61ST TO 90TH DAY (Part A Coinsurance per Benefit Period).....	100%
91ST TO 150TH DAY (Part A Coinsurance for 60 Lifetime Inpatient Reserve Days)	100%
151ST TO 515TH DAY …….. (limited to a lifetime maximum of 365 days and payable at the same rate Medicare would have paid had Medicare Part A Hospital days not been exhausted)	100%

SKILLED NURSING FACILITY CARE:	
FIRST 20 DAYS ……	0%
21ST THRU 100TH DAY, AMOUNT NOT PAID BY MEDICARE ……	100%
BLOOD TRANSFUSIONS (First three (3) Pints - Part A or B)	100%
REMAINDER OF MEDICARE APPROVED AMOUNT AFTER DEDUCTIBLE	20%

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

MEDICAL EXPENSES APPROVED BY MEDICARE:	
PART B DEDUCTIBLE AMOUNT OF MEDICARE APPROVED AMOUNTS	100%
REMAINDER OF MEDICARE APPROVED AMOUNTS	20%
PART-B EXCESS CHARGES ABOVE MEDICARE APPROVED AMOUNTS	100%

PARTS A & B

HOME HEALTH CARE, MEDICARE APPROVED SERVICES:	
DURABLE MEDICAL EQUIPMENT, PART B DEDUCTIBLE AMOUNT OF MEDICARE APPROVED AMOUNTS ……...	100%
REMAINDER OF MEDICARE APPROVED AMOUNTS AFTER DEDUCTIBLE....	20%

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL:	
FIRST $250 EACH CALENDAR YEAR ……	0%
REMAINDER OF CHARGES (LIFETIME MAXIMUM BENEFIT $50,000) ……	80%

To Inquire About Your Coverage, or to Express a Concern, Call us Toll-Free at:
Policyholder Services: [1-800-XXX-XXXX]
Claims Customer Service: [1-800-XXX-XXXX]
or Write to Us at:
American Continental Insurance Company
P. O. Box 2368
Brentwood, Tennessee 37027-2368

DEFINITIONS

Shown below are the defined terms used in your policy. These terms are capitalized wherever they appear in the policy.

ACCIDENT means accidental bodily Injury or Injuries causing Loss under this policy. Such Injuries must be caused directly and independent of disease or bodily infirmity or any other cause.

BENEFIT PERIOD means a Benefit Period as defined by Medicare.

COMPANY OFFICER means the President or Secretary.

EFFECTIVE DATE means the date your policy coverage begins at 12:01 A.M. where you live. Your policy Effective Date is listed on the policy schedule page.

HOSPITAL means Hospital as defined by Medicare.

INPATIENT HOSPITAL DEDUCTIBLE means the initial amount of Hospital expenses you incur in a Medicare Benefit Period as a resident bed patient under Medicare Part A. Medicare establishes the amount of the Inpatient Hospital Deductible. Medicare does not pay this amount.

INJURY or INJURIES means bodily Injury caused by an Accident and resulting directly and independently of all other causes.

LIFETIME INPATIENT RESERVE DAYS means additional days that Medicare will pay for when you are confined to a Hospital for more than 90 days in a Benefit Period.
.

LOSS means the incurring of Medicare Eligible Expenses while this policy is in force.

MATERIAL INFORMATION means a condition or combination of conditions you were requested to disclose on the application were not disclosed and which, if disclosed, would have required a different premium or caused us to deny issuing your policy.

MEDICALLY NECESSARY means that the service or supply is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and must:

1. Be prescribed by a Physician;
2. Be consistent with the diagnosis and treatment of such Injury or Sickness;
3. Be in accordance with the generally accepted standards of medical practice; and
4. Not be solely for the convenience of the Insured or the Physician.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965 as then constituted or later amended.

MEDICARE COINSURANCE means the portion of charges covered but not reimbursed by Medicare, excluding the Medicare deductibles, for which you are responsible.

MEDICARE ELIGIBLE EXPENSES means health care expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

MEDICARE PART B DEDUCTIBLE means the amount you must pay each calendar year before benefits will be paid under Medicare Part B. Medicare establishes the amount of the Part B Deductible. Medicare does not pay this amount. A calendar year begins on January 1, and ends on December 31.

PHYSICIAN means a Physician as defined by Medicare.

PREMIUM DUE DATE means the month and day your policy's premium payment is due. The frequency of the Premium Due Date can vary depending on whether your premiums are paid on a monthly, quarterly, semiannual, or annual basis.

RESPITE CARE means treatment that meets Medicare's definition of respite care.

SICKNESS means illness or disease which first manifests itself after your policy's Effective Date and while your policy is in force.

SKILLED NURSING FACILITY means a Skilled Nursing Facility as defined by Medicare.

WRITTEN NOTIFICATION means written notice that you are currently receiving medical assistance or that your medical assistance received has terminated. This notification should include: Insured's name, policy number, copy of the document which indicates the date you became eligible for medical assistance or a copy of the document which indicates the date medical assistance terminated.

Notice must be given by or on behalf of the Insured or the beneficiary to the Home Office, Attn: Policyholders Service Department, or to any authorized agent of the company.

BENEFIT PROVISIONS

BASIC ("CORE") BENEFITS

TO SUPPLEMENT BENEFITS UNDER PART A OF MEDICARE:

1. We will pay all Part A Medicare Coinsurance for inpatient Hospital confinement to the extent not covered by Medicare from the 61st day through 90th day in any Medicare Benefit Period.

2. We will pay all Part A Medicare Coinsurance incurred for each Lifetime Inpatient Reserve Day to the extent not covered by Medicare. Lifetime Inpatient Reserve Days are nonrenewable and limited to 60 days during your lifetime.

3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the Lifetime Inpatient Reserve Days, we will pay one hundred percent of the Part A Medicare Eligible Expenses for inpatient Hospital confinement. Benefits are payable at the same rate Medicare would have paid had Medicare Part A Hospital days not been exhausted. Medicare exhaustion benefits are limited to a lifetime maximum of 365 days of inpatient Hospital confinement.

4. We will pay under Medicare Parts A and B the reasonable cost of the first three 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

5. We will pay the co-payment/coinsurance amount for all Part A Medicare Eligible Expenses for hospice care and Respite Care.

TO SUPPLEMENT BENEFITS UNDER PART B OF MEDICARE:

1. We will pay all of the Medicare Coinsurance amount, or in the case of hospital outpatient department services, paid under a prospective payment system, the copayment amount of Medicare Part B eligible Expenses regardless of Hospital confinement, subject to the Medicare Part B Deductible.

ADDITIONAL BENEFITS

TO SUPPLEMENT BENEFITS UNDER PART A OF MEDICARE:

1. We will pay one hundred percent (100%) of the Medicare Part A Inpatient Hospital Deductible amount per Benefit Period.

2. We will pay for the actual billed charges up to the Medicare Coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital Skilled Nursing Facility care eligible under Medicare Part A. Such confinement must:

   a. begin on or after the Effective Date and while your coverage is in force;
   b. begin within 30 days following a Hospital confinement of 3 days or more;
   c. be for the same Injury or Sickness which required the Hospital confinement; and
   d. be under the direct and personal supervision of a Physician.

TO SUPPLEMENT BENEFITS UNDER PART B OF MEDICARE:

1. We will pay one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

2. We will pay for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.

3. We will pay, to the extent not covered by Medicare, 80% of the billed charges for Medicare Eligible Expenses for Medically Necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit “emergency care” shall mean care needed immediately because of an Injury or Sickness of sudden and unexpected onset.

CHANGES IN MEDICARE COINSURANCE AND DEDUCTIBLES

Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

EXCLUSIONS

We will not pay for:

1. Loss incurred while your policy is not in force, except as provided in the Extension of Benefits section of your policy;
2. Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force;
3. That portion of any Loss incurred which is paid for by Medicare;
4. Services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take-home drugs and eye refractions;
5. Services for which a charge is not normally made in the absence of insurance;
6. Loss that is payable under any other Medicare supplement insurance policy or certificate; or
7. Loss that is payable under any other insurance which paid benefits for the same Loss on an expense incurred basis.

RECEIPT OF MEDICAL ASSISTANCE

Benefits and premium(s) under this policy shall be suspended upon your request for any period, (that may be provided by law), in which you have applied for and qualified for the receipt of medical assistance under Title XIX of the Social Security Act (Medicaid), but **only** if you notify us within ninety (90) days after the date you became entitled to such assistance.

If such suspension occurs and if you lose entitlement to such medical assistance, this policy shall be automatically reinstituted, effective as of the date of termination of such entitlement, if you provide Written Notification of loss of such entitlement within ninety (90) days after the date of such loss of entitlement and pay the premium attributable to this period, effective as of the date of termination of such entitlement.

Benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if you lose coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if you provide notice of loss of coverage within 90 days after the date of loss.

If such reinstitution occurs:

1. Your policy shall not provide for any waiting period with respect to treatment of Pre-Existing Conditions;

2. Your benefits provided under the reinstitution will be substantially the same as the benefits in effect before the date of such suspension; and

3. Your premium classification terms provided under the reinstitution will be at least as favorable to you as the premium terms that would have applied had this policy not been suspended.

POLICY TERMINATION

Your policy will terminate on the earliest of:

1. The date we receive your written request to cancel your policy (in which case the grace period will not apply);
2. The date your policy is replaced by another Medicare supplement or Medicare Select policy or by a Part C Medicare Advantage plan (in which case the grace period will not apply);
3. The Premium Due Date, if sufficient premium has not been paid before the end of the grace period; or
4. The date and time of your death.

In the event of cancellation or death, we will promptly return the unearned portion of any premium paid.

POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES: This policy, the application and any attached papers constitute the entire contract. No one has the authority to change this policy or to waive any of its provisions unless the change is approved in writing by a Company Officer. The approval must be written on or attached to this policy.

TIME LIMIT ON CERTAIN DEFENSES:

1. **Misstatement in your application:** We issued your policy based on information we were provided on your application. Any incorrect or omitted Material Information in your application may cause your policy to be rescinded (voided) back to the Effective Date of your policy or a claim to be denied.

2. **Time limit on certain defenses:**

   a. We may rescind (void) this policy or deny a claim for Loss incurred within 2 years from your policy Effective Date because of misstatement in your application.

   b. We may rescind (void) your policy or deny a claim for Loss incurred any time after 2 years from your policy's Effective Date only for fraudulent misstatement in your application.

GRACE PERIOD: A grace period of 31 days from your Premium Due Date will be allowed for late payment of premium. During such grace period, this policy will not lapse as long as you pay your full premium before the end of the grace period.

REINSTATEMENT: If any premium is not paid within the time your payment is due, a subsequent acceptance of premium by us or by any agent authorized by us to accept such premium, without requiring an application for reinstatement, shall reinstate your policy. However, if we or our agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, your policy will be reinstated only upon approval of the application by us or, lacking such approval, upon the 45th day following the date of the conditional receipt, unless we have previously notified you in writing of our disapproval of your application. If the application for reinstatement is disapproved, any premium received will be returned to you. If the application for reinstatement is approved, the reinstated policy will cover only Loss resulting from Injury or Sickness sustained after the Effective Date of reinstatement. In all other respects, you and the company shall have the same rights under this policy as were in effect before it lapsed, subject to the provisions of any rider which may be attached in connection with the reinstatement.

NOTICE OF CLAIM: Written notice of claim must be given to the company within twenty days after the beginning of any Loss covered by this policy. If notice cannot be given within that period, it must be given as soon as is reasonably possible. The notice will be considered sufficient if it identifies you and is given to the company at its Home Office or to any authorized agent of the company.

CLAIM FORMS: The company, after receiving notice of claim, will furnish to the claimant forms for filing proof of Loss. If forms are not furnished within 15 days after the giving of such notice, the claimant will be considered to have met the requirements of this policy for proof of Loss if the company is furnished proof of Loss as stated below.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this policy will be paid promptly after the company receives suitable written proof of Loss.

PROOF OF LOSS: Written proof of Loss must be sent to the company at its Home Office within 90 days after the date of Loss. Failure to furnish proof within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

PAYMENT OF CLAIMS: All benefits are payable to you unless we receive proof of an assignment of benefits to pay your health care provider. At your death, any accrued benefits unpaid, and which are not assigned, or unearned premium will be paid to your estate.

REFUND OF UNEARNED PREMIUM UPON DEATH OF INSURED: The company shall refund any premium paid for the period beyond the end of the policy month in which the death occurred. Unearned premium shall be paid in a lump sum to your estate no later than 30 days after receipt of proof of death is received by the company.

PHYSICAL EXAMINATIONS AND AUTOPSY: We, at our expense, shall have the right and opportunity to have a Physician examine you when and as often as we may reasonably require while a claim is pending under your policy, and to request an autopsy in case of death where it is not prohibited by law.

LEGAL ACTION: No action at law or in equity can be brought to recover on this policy until 60 days after written proof of Loss has been given to the company. No action can be brought after 3 years from the date written proof of Loss is required.

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its Effective Date, is in conflict with the statutes of the state in which you reside on such date is automatically changed to meet the minimum requirements of such statutes.

ASSIGNMENT: No assignment of interest under this policy will be binding upon the company unless notice of the assignment is received at the Home Office of the company. The company does not assume any responsibility for the assignment's validity.

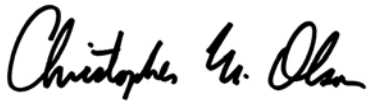
MISSTATEMENT OF AGE OR GENDER: If your age or gender has been misstated in your application for this policy, your premium will be adjusted based on your correct age or gender upon reasonable notice to you. If based on your true age this policy would not have been issued, we will be liable only for the refund of premiums paid for this policy.

UNPAID PREMIUMS: When benefits are paid for a claim under this policy, any premium due and unpaid may be deducted, at our option, from the benefits payable.

EXTENSION OF BENEFITS: Termination of your policy shall be without prejudice to any continuous Loss which commenced while your policy was in force, but the extension of benefits beyond the period that your policy was in force is: (a) subject to your continuous total disability; (b) limited to the duration of the Medicare Benefit Period or, if none is applicable, payment of the maximum benefits; and (c) limited to the covered Injury or Sickness causing the continuous loss beginning while your policy was in force. Receipt of Medicare Part D benefits will not be considered in determining a continuous Loss.

TERM OF COVERAGE: Your coverage starts on the Effective Date at 12:01 A.M. where you live. It ends at 12:01 A.M. where you live on the termination date as described in the Policy Termination section.

IN WITNESS WHEREOF, American Continental Insurance Company has caused this policy to be signed and attested by its authorized Company Officers.



President

Secretary

AMERICAN CONTINENTAL INSURANCE COMPANY

HOME OFFICE
101 Continental Place
Brentwood, Tennessee 37027
Telephone: 1-800-264-4000

MEDICARE SUPPLEMENT POLICY

THIS IS A PLAN "F"

If you need information or have any questions regarding your policy, please contact:

Policyholder Services
P. O. Box 2368
Brentwood, Tennessee 37024-1188
(800) 264-4000

AMERICAN CONTINENTAL INSURANCE COMPANY

HOME OFFICE
101 Continental Place
Brentwood, Tennessee 37027
Telephone: 1-800-264-4000

PREMIUMS ARE SUBJECT TO CHANGE
MEDICARE SUPPLEMENT POLICY – PLAN HIGH DEDUCTIBLE F

THIS POLICY PROVIDES BENEFITS FOR LOSS DUE TO INJURY OR SICKNESS AS HEREIN LIMITED AND PROVIDED.

Notice to buyer: This policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review all policy limitations.

In this policy the person insured is also called "you" or "your". American Continental Insurance Company is called "us", "we", "our", or "the company." The Definitions section defines other words and terms used in this policy.

In consideration of your payment of the required premiums for this policy, the company insures you against Loss caused by Injury or Sickness as herein limited and provided. Coverage is provided subject to the terms of this policy. The amount of the initial premium and the Effective Date of your policy are shown on the Policy Schedule. This policy is a legal contract between you and the company. READ YOUR POLICY CAREFULLY.

RIGHT TO EXAMINE POLICY FOR THIRTY (30) DAYS: You have 30 days after receipt of this policy to examine its provisions. During that 30-day period, if you are dissatisfied with the policy, it may be returned to the company at its Home Office, to any state office of the company or to the agent from whom it was purchased. Immediately upon such return, this policy shall be void from the beginning and any premium paid will be refunded.

GUARANTEED RENEWABLE: You have the right to renew this policy, for consecutive terms, by paying the required premium before the end of each grace period. You have the right to renew this policy regardless of changes in your physical, mental or health conditions.

PREMIUM AGREEMENT: On each annual anniversary of your Effective Date, premiums for this policy may be changed if there is any change in rates for this policy. Any change in premium will apply to all covered persons with your same policy type based on the issue state of your policy. For any premium change under this paragraph, we will give you at least 30 days advance notice in writing of such premium change.

CHANGE IN BENEFITS: Your benefits will change automatically to correspond with changes in Medicare.

IMPORTANT NOTICE

Please read the copy of your application attached to your policy. Omissions or misstatements in your application could cause a claim to be denied or your policy rescinded. If your policy is rescinded, it will be voided back to its Effective Date and you will have no insurance coverage under your policy. Carefully check your application and write to the Home Office within 10 days of the receipt of your policy if any information shown on it is not correct and complete or if any past medical history is left out of your application. Your application is part of your policy and your policy was issued on the basis that the answers to all questions and information shown on your application are correct and complete.

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American Continental Insurance Company
POLICY SCHEDULE

PLAN HIGH DEDUCTIBLE F

INSURED: [John Doe] AGE: [65] GENDER: [Male]

ADDRESS: [123 Main St.
Anytown, USA xxxxx]

POLICY NUMBER: [050-10-9999X] POLICY EFFECTIVE DATE: [01/01/10]

INITIAL PREMIUM: [$495.00] PREMIUM MODE: [ANNUAL]

MEDICARE (PART A) - HOSPITAL SERVICES

***DEDUCTIBLE: SET BY MEDICARE EACH YEAR**	*AFTER YOU PAY THE DEDUCTIBLE THIS POLICY PAYS
DAILY BENEFIT NOT COVERED BY MEDICARE:	
FIRST 60 DAYS (Part-A Deductible per Benefit Period) .....;.....	100%
61ST TO 90TH DAY (Part A Coinsurance per Benefit Period).....	100%
91ST TO 150TH DAY (Part A Coinsurance for 60 Lifetime Inpatient Reserve Days)	100%
151ST TO 515TH DAY …….. (limited to a lifetime maximum of 365 days and payable at the same rate Medicare would have paid had Medicare Part A Hospital days not been exhausted)	100%
SKILLED NURSING FACILITY CARE:	
FIRST 20 DAYS …….	0%
21ST THRU 100TH DAY, AMOUNT NOT PAID BY MEDICARE ……	100%
BLOOD TRANSFUSIONS (First three (3) Pints - Part A or B)	100%
REMAINDER OF MEDICARE APPROVED AMOUNT AFTER DEDUCTIBLE	20%

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

MEDICAL EXPENSES APPROVED BY MEDICARE:	
PART B DEDUCTIBLE AMOUNT OF MEDICARE APPROVED AMOUNTS	100%
REMAINDER OF MEDICARE APPROVED AMOUNTS	20%
PART-B EXCESS CHARGES ABOVE MEDICARE APPROVED AMOUNTS	100%

PARTS A & B

HOME HEALTH CARE, MEDICARE APPROVED SERVICES:	
DURABLE MEDICAL EQUIPMENT, PART B DEDUCTIBLE AMOUNT OF MEDICARE APPROVED AMOUNTS ……...	100%
REMAINDER OF MEDICARE APPROVED AMOUNTS AFTER DEDUCTIBLE....	20%

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL:	
FIRST $250 EACH CALENDAR YEAR …….	0%
REMAINDER OF CHARGES (LIFETIME MAXIMUM BENEFIT $50,000) ……	80%

To Inquire About Your Coverage, or to Express a Concern, Call us Toll-Free at:
Policyholder Services: [1-800-XXX-XXXX]
Claims Customer Service: [1-800-XXX-XXXX]
or Write to Us at:
American Continental Insurance Company
P. O. Box 2368
Brentwood, Tennessee 37027-2368

DEFINITIONS

Shown below are the defined terms used in your policy. These terms are capitalized wherever they appear in the policy.

ACCIDENT means accidental bodily Injury or Injuries causing Loss under this policy. Such Injuries must be caused directly and independent of disease or bodily infirmity or any other cause.

BENEFIT PERIOD means a Benefit Period as defined by Medicare.

COMPANY OFFICER means the President or Secretary.

EFFECTIVE DATE means the date your policy coverage begins at 12:01 A.M. where you live. Your policy Effective Date is listed on the policy schedule page.

HOSPITAL means Hospital as defined by Medicare.

INPATIENT HOSPITAL DEDUCTIBLE means the initial amount of Hospital expenses you incur in a Medicare Benefit Period as a resident bed patient under Medicare Part A. Medicare establishes the amount of the Inpatient Hospital Deductible. Medicare does not pay this amount.

INJURY or INJURIES means bodily Injury caused by an Accident and resulting directly and independently of all other causes.

LIFETIME INPATIENT RESERVE DAYS means additional days that Medicare will pay for when you are confined to a Hospital for more than 90 days in a Benefit Period.
.

LOSS means the incurring of Medicare Eligible Expenses while this policy is in force.

MATERIAL INFORMATION means a condition or combination of conditions you were requested to disclose on the application were not disclosed and which, if disclosed, would have required a different premium or caused us to deny issuing your policy.

MEDICALLY NECESSARY means that the service or supply is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and must:

1. Be prescribed by a Physician;
2. Be consistent with the diagnosis and treatment of such Injury or Sickness;
3. Be in accordance with the generally accepted standards of medical practice; and
4. Not be solely for the convenience of the Insured or the Physician.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965 as then constituted or later amended.

MEDICARE COINSURANCE means the portion of charges covered but not reimbursed by Medicare, excluding the Medicare deductibles, for which you are responsible.

MEDICARE ELIGIBLE EXPENSES means health care expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

MEDICARE PART B DEDUCTIBLE means the amount you must pay each calendar year before benefits will be paid under Medicare Part B. Medicare establishes the amount of the Part B Deductible. Medicare does not pay this amount. A calendar year begins on January 1, and ends on December 31.

PHYSICIAN means a Physician as defined by Medicare.

PREMIUM DUE DATE means the month and day your policy's premium payment is due. The frequency of the Premium Due Date can vary depending on whether your premiums are paid on a monthly, quarterly, semiannual, or annual basis.

RESPITE CARE means treatment that meets Medicare's definition of respite care.

SICKNESS means illness or disease which first manifests itself after your policy's Effective Date and while your policy is in force.

SKILLED NURSING FACILITY means a Skilled Nursing Facility as defined by Medicare.

WRITTEN NOTIFICATION means written notice that you are currently receiving medical assistance or that your medical assistance received has terminated. This notification should include: Insured's name, policy number, copy of the document which indicates the date you became eligible for medical assistance or a copy of the document which indicates the date medical assistance terminated.

Notice must be given by or on behalf of the Insured or the beneficiary to the Home Office, Attn: Policyholders Service Department, or to any authorized agent of the company.

BENEFIT PROVISIONS

The High Deductible Plan F offers the same benefits as Plan F after you have paid a calendar year deductible. Benefits from the high deductible plan will not begin until out-of-pocket expenses total the deductible. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and Part B, but does not include the Plan's separate Foreign Travel Emergency Deductible.

The deductible for the policy will be adjusted annually

BASIC ("CORE") BENEFITS

TO SUPPLEMENT BENEFITS UNDER PART A OF MEDICARE:

1. We will pay all Part A Medicare Coinsurance for inpatient Hospital confinement to the extent not covered by Medicare from the 61st day through 90th day in any Medicare Benefit Period.

2. We will pay all Part A Medicare Coinsurance incurred for each Lifetime Inpatient Reserve Day to the extent not covered by Medicare. Lifetime Inpatient Reserve Days are nonrenewable and limited to 60 days during your lifetime.

3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the Lifetime Inpatient Reserve Days, we will pay one hundred percent of the Part A Medicare Eligible Expenses for inpatient Hospital confinement. Benefits are payable at the same rate Medicare would have paid had Medicare Part A Hospital days not been exhausted. Medicare exhaustion benefits are limited to a lifetime maximum of 365 days of inpatient Hospital confinement.

4. We will pay under Medicare Parts A and B the reasonable cost of the first three 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

5. We will pay the co-payment/coinsurance amount for all Part A Medicare Eligible Expenses for hospice care and Respite Care.

TO SUPPLEMENT BENEFITS UNDER PART B OF MEDICARE:

1. We will pay all of the Medicare Coinsurance amount, or in the case of hospital outpatient department services, paid under a prospective payment system, the copayment amount of Medicare Part B eligible Expenses regardless of Hospital confinement, subject to the Medicare Part B Deductible.

ADDITIONAL BENEFITS

TO SUPPLEMENT BENEFITS UNDER PART A OF MEDICARE:

1. We will pay one hundred percent (100%) of the Medicare Part A Inpatient Hospital Deductible amount per Benefit Period.

2. We will pay for the actual billed charges up to the Medicare Coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital Skilled Nursing Facility care eligible under Medicare Part A. Such confinement must:

   a. begin on or after the Effective Date and while your coverage is in force;
   b. begin within 30 days following a Hospital confinement of 3 days or more;
   c. be for the same Injury or Sickness which required the Hospital confinement; and
   d. be under the direct and personal supervision of a Physician.

TO SUPPLEMENT BENEFITS UNDER PART B OF MEDICARE:

1. We will pay one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

2. We will pay for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.

3. We will pay, to the extent not covered by Medicare, 80% of the billed charges for Medicare Eligible Expenses for Medically Necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit “emergency care” shall mean care needed immediately because of an Injury or Sickness of sudden and unexpected onset.

CHANGES IN MEDICARE COINSURANCE AND DEDUCTIBLES

Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

EXCLUSIONS

We will not pay for:

1. Loss incurred while your policy is not in force, except as provided in the Extension of Benefits section of your policy;
2. Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force;
3. That portion of any Loss incurred which is paid for by Medicare;

4. Services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take-home drugs and eye refractions;
5. Services for which a charge is not normally made in the absence of insurance;
6. Loss that is payable under any other Medicare supplement insurance policy or certificate; or
7. Loss that is payable under any other insurance which paid benefits for the same Loss on an expense incurred basis.

RECEIPT OF MEDICAL ASSISTANCE

Benefits and premium(s) under this policy shall be suspended upon your request for any period, (that may be provided by law), in which you have applied for and qualified for the receipt of medical assistance under Title XIX of the Social Security Act (Medicaid), but **only** if you notify us within ninety (90) days after the date you became entitled to such assistance.

If such suspension occurs and if you lose entitlement to such medical assistance, this policy shall be automatically reinstituted, effective as of the date of termination of such entitlement, if you provide Written Notification of loss of such entitlement within ninety (90) days after the date of such loss of entitlement and pay the premium attributable to this period, effective as of the date of termination of such entitlement.

Benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if you lose coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if you provide notice of loss of coverage within 90 days after the date of loss.

If such reinstitution occurs:

1. Your policy shall not provide for any waiting period with respect to treatment of Pre-Existing Conditions;

2. Your benefits provided under the reinstitution will be substantially the same as the benefits in effect before the date of such suspension; and

3. Your premium classification terms provided under the reinstitution will be at least as favorable to you as the premium terms that would have applied had this policy not been suspended.

POLICY TERMINATION

Your policy will terminate on the earliest of:

1. The date we receive your written request to cancel your policy (in which case the grace period will not apply);
2. The date your policy is replaced by another Medicare supplement or Medicare Select policy or by a Part C Medicare Advantage plan (in which case the grace period will not apply);
3. The Premium Due Date, if sufficient premium has not been paid before the end of the grace period; or
4. The date and time of your death.

In the event of cancellation or death, we will promptly return the unearned portion of any premium paid.

POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES: This policy, the application and any attached papers constitute the entire contract. No one has the authority to change this policy or to waive any of its provisions unless the change is approved in writing by a Company Officer. The approval must be written on or attached to this policy.

TIME LIMIT ON CERTAIN DEFENSES:

1. **Misstatement in your application:** We issued your policy based on information we were provided on your application. Any incorrect or omitted Material Information in your application may cause your policy to be rescinded (voided) back to the Effective Date of your policy or a claim to be denied.

2. **Time limit on certain defenses:**

   a. We may rescind (void) this policy or deny a claim for Loss incurred within 2 years from your policy Effective Date because of misstatement in your application.

   b. We may rescind (void) your policy or deny a claim for Loss incurred any time after 2 years from your policy's Effective Date only for fraudulent misstatement in your application.

GRACE PERIOD: A grace period of 31 days from your Premium Due Date will be allowed for late payment of premium. During such grace period, this policy will not lapse as long as you pay your full premium before the end of the grace period.

REINSTATEMENT: If any premium is not paid within the time your payment is due, a subsequent acceptance of premium by us or by any agent authorized by us to accept such premium, without requiring an application for reinstatement, shall reinstate your policy. However, if we or our agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, your policy will be reinstated only upon approval of the application by us or, lacking such approval, upon the 45th day following the date of the conditional receipt, unless we have previously notified you in writing of our disapproval of your application. If the application for reinstatement is disapproved, any premium received will be returned to you. If the application for reinstatement is approved, the reinstated policy will cover only Loss resulting from Injury or Sickness sustained after the Effective Date of reinstatement. In all other respects, you and the company shall have the same rights under this policy as were in effect before it lapsed, subject to the provisions of any rider which may be attached in connection with the reinstatement.

NOTICE OF CLAIM: Written notice of claim must be given to the company within twenty days after the beginning of any Loss covered by this policy. If notice cannot be given within that period, it must be given as soon as is reasonably possible. The notice will be considered sufficient if it identifies you and is given to the company at its Home Office or to any authorized agent of the company.

CLAIM FORMS: The company, after receiving notice of claim, will furnish to the claimant forms for filing proof of Loss. If forms are not furnished within 15 days after the giving of such notice, the claimant will be considered to have met the requirements of this policy for proof of Loss if the company is furnished proof of Loss as stated below.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this policy will be paid promptly after the company receives suitable written proof of Loss.

PROOF OF LOSS: Written proof of Loss must be sent to the company at its Home Office within 90 days after the date of Loss. Failure to furnish proof within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

PAYMENT OF CLAIMS: All benefits are payable to you unless we receive proof of an assignment of benefits to pay your health care provider. At your death, any accrued benefits unpaid, and which are not assigned, or unearned premium will be paid to your estate.

REFUND OF UNEARNED PREMIUM UPON DEATH OF INSURED: The company shall refund any premium paid for the period beyond the end of the policy month in which the death occurred. Unearned premium shall be paid in a lump sum to your estate no later than 30 days after receipt of proof of death is received by the company.

PHYSICAL EXAMINATIONS AND AUTOPSY: We, at our expense, shall have the right and opportunity to have a Physician examine you when and as often as we may reasonably require while a claim is pending under your policy, and to request an autopsy in case of death where it is not prohibited by law.

LEGAL ACTION: No action at law or in equity can be brought to recover on this policy until 60 days after written proof of Loss has been given to the company. No action can be brought after 3 years from the date written proof of Loss is required.

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its Effective Date, is in conflict with the statutes of the state in which you reside on such date is automatically changed to meet the minimum requirements of such statutes.

ASSIGNMENT: No assignment of interest under this policy will be binding upon the company unless notice of the assignment is received at the Home Office of the company. The company does not assume any responsibility for the assignment's validity.

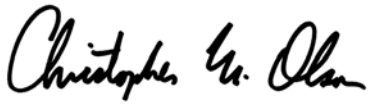
MISSTATEMENT OF AGE OR GENDER: If your age or gender has been misstated in your application for this policy, your premium will be adjusted based on your correct age or gender upon reasonable notice to you. If based on your true age this policy would not have been issued, we will be liable only for the refund of premiums paid for this policy.

UNPAID PREMIUMS: When benefits are paid for a claim under this policy, any premium due and unpaid may be deducted, at our option, from the benefits payable.

EXTENSION OF BENEFITS: Termination of your policy shall be without prejudice to any continuous Loss which commenced while your policy was in force, but the extension of benefits beyond the period that your policy was in force is: (a) subject to your continuous total disability; (b) limited to the duration of the Medicare Benefit Period or, if none is applicable, payment of the maximum benefits; and (c) limited to the covered Injury or Sickness causing the continuous loss beginning while your policy was in force. Receipt of Medicare Part D benefits will not be considered in determining a continuous Loss.

TERM OF COVERAGE: Your coverage starts on the Effective Date at 12:01 A.M. where you live. It ends at 12:01 A.M. where you live on the termination date as described in the Policy Termination section.

IN WITNESS WHEREOF, American Continental Insurance Company has caused this policy to be signed and attested by its authorized Company Officers.



President

Secretary

AMERICAN CONTINENTAL INSURANCE COMPANY

HOME OFFICE
101 Continental Place
Brentwood, Tennessee 37027
Telephone: 1-800-264-4000

MEDICARE SUPPLEMENT POLICY

THIS IS A PLAN "HIGH DEDUCTIBLE F"

If you need information or have any questions regarding your policy, please contact:

Policyholder Services
P. O. Box 2368
Brentwood, Tennessee 37024-1188
(800) 264-4000

AMERICAN CONTINENTAL INSURANCE COMPANY

HOME OFFICE
101 Continental Place
Brentwood, Tennessee 37027
Telephone: 1-800-264-4000

PREMIUMS ARE SUBJECT TO CHANGE
MEDICARE SUPPLEMENT POLICY – PLAN G

THIS POLICY PROVIDES BENEFITS FOR LOSS DUE TO INJURY OR SICKNESS AS HEREIN LIMITED AND PROVIDED.

Notice to buyer: This policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review all policy limitations.

In this policy the person insured is also called "you" or "your". American Continental Insurance Company is called "us", "we", "our", or "the company." The Definitions section defines other words and terms used in this policy.

In consideration of your payment of the required premiums for this policy, the company insures you against Loss caused by Injury or Sickness as herein limited and provided. Coverage is provided subject to the terms of this policy. The amount of the initial premium and the Effective Date of your policy are shown on the Policy Schedule. This policy is a legal contract between you and the company. READ YOUR POLICY CAREFULLY.

RIGHT TO EXAMINE POLICY FOR THIRTY (30) DAYS: You have 30 days after receipt of this policy to examine its provisions. During that 30-day period, if you are dissatisfied with the policy, it may be returned to the company at its Home Office, to any state office of the company or to the agent from whom it was purchased. Immediately upon such return, this policy shall be void from the beginning and any premium paid will be refunded.

GUARANTEED RENEWABLE: You have the right to renew this policy, for consecutive terms, by paying the required premium before the end of each grace period. You have the right to renew this policy regardless of changes in your physical, mental or health conditions.

PREMIUM AGREEMENT: On each annual anniversary of your Effective Date, premiums for this policy may be changed if there is any change in rates for this policy. Any change in premium will apply to all covered persons with your same policy type based on the issue state of your policy. For any premium change under this paragraph, we will give you at least 30 days advance notice in writing of such premium change.

CHANGE IN BENEFITS: Your benefits will change automatically to correspond with changes in Medicare.

IMPORTANT NOTICE

Please read the copy of your application attached to your policy. Omissions or misstatements in your application could cause a claim to be denied or your policy rescinded. If your policy is rescinded, it will be voided back to its Effective Date and you will have no insurance coverage under your policy. Carefully check your application and write to the Home Office within 10 days of the receipt of your policy if any information shown on it is not correct and complete or if any past medical history is left out of your application. Your application is part of your policy and your policy was issued on the basis that the answers to all questions and information shown on your application are correct and complete.

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American Continental Insurance Company
POLICY SCHEDULE

PLAN G

INSURED: [John Doe] AGE: [65] GENDER: [Male]

ADDRESS: [123 Main St.
Anytown, USA xxxxx]

POLICY NUMBER: [050-10-9999X] POLICY EFFECTIVE DATE: [01/01/10]

INITIAL PREMIUM: [$495.00] PREMIUM MODE: [ANNUAL]

MEDICARE (PART A) - HOSPITAL SERVICES

DAILY BENEFIT NOT COVERED BY MEDICARE:	THIS POLICY PAYS
FIRST 60 DAYS (Part-A Deductible per Benefit Period) .....;.....	100%
61ST TO 90TH DAY (Part A Coinsurance per Benefit Period).....	100%
91ST TO 150TH DAY (Part A Coinsurance for 60 Lifetime Inpatient Reserve Days)	100%
151ST TO 515TH DAY …….. (limited to a lifetime maximum of 365 days and payable at the same rate Medicare would have paid had Medicare Part A Hospital days not been exhausted)	100%

SKILLED NURSING FACILITY CARE:	
FIRST 20 DAYS ……	0%
21ST THRU 100TH DAY, AMOUNT NOT PAID BY MEDICARE ……	100%
BLOOD TRANSFUSIONS (First three (3) Pints - Part A or B)	100%
REMAINDER OF MEDICARE APPROVED AMOUNT AFTER DEDUCTIBLE	20%

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

MEDICAL EXPENSES APPROVED BY MEDICARE:	
PART B DEDUCTIBLE AMOUNT OF MEDICARE APPROVED AMOUNTS	0%
REMAINDER OF MEDICARE APPROVED AMOUNTS	20%
PART-B EXCESS CHARGES ABOVE MEDICARE APPROVED AMOUNTS	80%

PARTS A & B

HOME HEALTH CARE, MEDICARE APPROVED SERVICES:	
DURABLE MEDICAL EQUIPMENT, PART B DEDUCTIBLE AMOUNT OF MEDICARE APPROVED AMOUNTS ……...	0%
REMAINDER OF MEDICARE APPROVED AMOUNTS AFTER DEDUCTIBLE....	20%
AT-HOME RECOVERY SERVICES (NOT COVERED BY MEDICARE)	
BENEFIT FOR EACH VISIT (LIMITED TO $40 PER VISIT) …… …	100%
LIMITED TO MEDICARE APPROVED VISITS, MAXIMUM PER WEEK ……	7
CALENDAR YEAR MAXIMUM ……	$1,600

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL:	
FIRST $250 EACH CALENDAR YEAR ……	0%
REMAINDER OF CHARGES (LIFETIME MAXIMUM BENEFIT $50,000) ……	80%

To Inquire About Your Coverage, or to Express a Concern, Call us Toll-Free at:
Policyholder Services: [1-800-XXX-XXXX]
Claims Customer Service: [1-800-XXX-XXXX]
or Write to Us at:
American Continental Insurance Company
P. O. Box 2368
Brentwood, Tennessee 37027-2368

DEFINITIONS

Shown below are the defined terms used in your policy. These terms are capitalized wherever they appear in the policy.

ACCIDENT means accidental bodily Injury or Injuries causing Loss under this policy. Such Injuries must be caused directly and independent of disease or bodily infirmity or any other cause.

BENEFIT PERIOD means a Benefit Period as defined by Medicare.

COMPANY OFFICER means the President or Secretary.

EFFECTIVE DATE means the date your policy coverage begins at 12:01 A.M. where you live. Your policy Effective Date is listed on the policy schedule page.

HOSPITAL means Hospital as defined by Medicare.

INPATIENT HOSPITAL DEDUCTIBLE means the initial amount of Hospital expenses you incur in a Medicare Benefit Period as a resident bed patient under Medicare Part A. Medicare establishes the amount of the Inpatient Hospital Deductible. Medicare does not pay this amount.

INJURY or INJURIES means bodily Injury caused by an Accident and resulting directly and independently of all other causes.

LIFETIME INPATIENT RESERVE DAYS means additional days that Medicare will pay for when you are confined to a Hospital for more than 90 days in a Benefit Period.
.

LOSS means the incurring of Medicare Eligible Expenses while this policy is in force.

MATERIAL INFORMATION means a condition or combination of conditions you were requested to disclose on the application were not disclosed and which, if disclosed, would have required a different premium or caused us to deny issuing your policy.

MEDICALLY NECESSARY means that the service or supply is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and must:

1. Be prescribed by a Physician;
2. Be consistent with the diagnosis and treatment of such Injury or Sickness;
3. Be in accordance with the generally accepted standards of medical practice; and
4. Not be solely for the convenience of the Insured or the Physician.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965 as then constituted or later amended.

MEDICARE COINSURANCE means the portion of charges covered but not reimbursed by Medicare, excluding the Medicare deductibles, for which you are responsible.

MEDICARE ELIGIBLE EXPENSES means health care expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

MEDICARE PART B DEDUCTIBLE means the amount you must pay each calendar year before benefits will be paid under Medicare Part B. Medicare establishes the amount of the Part B Deductible. Medicare does not pay this amount. A calendar year begins on January 1, and ends on December 31.

PHYSICIAN means a Physician as defined by Medicare.

PREMIUM DUE DATE means the month and day your policy's premium payment is due. The frequency of the Premium Due Date can vary depending on whether your premiums are paid on a monthly, quarterly, semiannual, or annual basis.

RESPITE CARE means treatment that meets Medicare's definition of respite care.

SICKNESS means illness or disease which first manifests itself after your policy's Effective Date and while your policy is in force.

SKILLED NURSING FACILITY means a Skilled Nursing Facility as defined by Medicare.

WRITTEN NOTIFICATION means written notice that you are currently receiving medical assistance or that your medical assistance received has terminated. This notification should include: Insured's name, policy number, copy of the document which indicates the date you became eligible for medical assistance or a copy of the document which indicates the date medical assistance terminated.

Notice must be given by or on behalf of the Insured or the beneficiary to the Home Office, Attn: Policyholders Service Department, or to any authorized agent of the company.

BENEFIT PROVISIONS

BASIC ("CORE") BENEFITS

TO SUPPLEMENT BENEFITS UNDER PART A OF MEDICARE:

1. We will pay all Part A Medicare Coinsurance for inpatient Hospital confinement to the extent not covered by Medicare from the 61st day through 90th day in any Medicare Benefit Period.

2. We will pay all Part A Medicare Coinsurance incurred for each Lifetime Inpatient Reserve Day to the extent not covered by Medicare. Lifetime Inpatient Reserve Days are nonrenewable and limited to 60 days during your lifetime.

3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the Lifetime Inpatient Reserve Days, we will pay one hundred percent of the Part A Medicare Eligible Expenses for inpatient Hospital confinement. Benefits are payable at the same rate Medicare would have paid had Medicare Part A Hospital days not been exhausted. Medicare exhaustion benefits are limited to a lifetime maximum of 365 days of inpatient Hospital confinement.

4. We will pay under Medicare Parts A and B the reasonable cost of the first three 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

5. We will pay the co-payment/coinsurance amount for all Part A Medicare Eligible Expenses for hospice care and Respite Care.

TO SUPPLEMENT BENEFITS UNDER PART B OF MEDICARE:

1. After the Medicare Part B Deductible has been satisfied, we will pay the Medicare Coinsurance amount applicable to Part B Medicare Eligible Expenses. In the case of Hospital outpatient department services under a prospective payment system, we will pay the co-payment amount.

ADDITIONAL BENEFITS

TO SUPPLEMENT BENEFITS UNDER PART A OF MEDICARE:

1. We will pay one hundred percent (100%) of the Medicare Part A Inpatient Hospital Deductible amount per Benefit Period.

2. We will pay for the actual billed charges up to the Medicare Coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital Skilled Nursing Facility care eligible under Medicare Part A. Such confinement must:

   a. begin on or after the Effective Date and while your coverage is in force;
   b. begin within 30 days following a Hospital confinement of 3 days or more;
   c. be for the same Injury or Sickness which required the Hospital confinement; and
   d. be under the direct and personal supervision of a Physician.

TO SUPPLEMENT BENEFITS UNDER PART B OF MEDICARE:

1. We will pay for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge.

2. We will pay, to the extent not covered by Medicare, 80% of the billed charges for Medicare Eligible Expenses for Medically Necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit “emergency care” shall mean care needed immediately because of an Injury or Sickness of sudden and unexpected onset.

CHANGES IN MEDICARE COINSURANCE AND DEDUCTIBLES

Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

EXCLUSIONS

We will not pay for:

1. Loss incurred while your policy is not in force, except as provided in the Extension of Benefits section of your policy;
2. Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force;
3. That portion of any Loss incurred which is paid for by Medicare;
4. Services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take-home drugs and eye refractions;
5. Services for which a charge is not normally made in the absence of insurance;
6. Loss that is payable under any other Medicare supplement insurance policy or certificate; or
7. Loss that is payable under any other insurance which paid benefits for the same Loss on an expense incurred basis.

RECEIPT OF MEDICAL ASSISTANCE

Benefits and premium(s) under this policy shall be suspended upon your request for any period, (that may be provided by law), in which you have applied for and qualified for the receipt of medical assistance under Title XIX of the Social Security Act (Medicaid), but **only** if you notify us within ninety (90) days after the date you became entitled to such assistance.

If such suspension occurs and if you lose entitlement to such medical assistance, this policy shall be automatically reinstituted, effective as of the date of termination of such entitlement, if you provide Written Notification of loss of such entitlement within ninety (90) days after the date of such loss of entitlement and pay the premium attributable to this period, effective as of the date of termination of such entitlement.

Benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if you lose coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if you provide notice of loss of coverage within 90 days after the date of loss.

If such reinstitution occurs:

1. Your policy shall not provide for any waiting period with respect to treatment of Pre-Existing Conditions;

2. Your benefits provided under the reinstitution will be substantially the same as the benefits in effect before the date of such suspension; and

3. Your premium classification terms provided under the reinstitution will be at least as favorable to you as the premium terms that would have applied had this policy not been suspended.

POLICY TERMINATION

Your policy will terminate on the earliest of:

1. The date we receive your written request to cancel your policy (in which case the grace period will not apply);
2. The date your policy is replaced by another Medicare supplement or Medicare Select policy or by a Part C Medicare Advantage plan (in which case the grace period will not apply);
3. The Premium Due Date, if sufficient premium has not been paid before the end of the grace period; or
4. The date and time of your death.

In the event of cancellation or death, we will promptly return the unearned portion of any premium paid.

POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES: This policy, the application and any attached papers constitute the entire contract. No one has the authority to change this policy or to waive any of its provisions unless the change is approved in writing by a Company Officer. The approval must be written on or attached to this policy.

TIME LIMIT ON CERTAIN DEFENSES:

1. **Misstatement in your application:** We issued your policy based on information we were provided on your application. Any incorrect or omitted Material Information in your application may cause your policy to be rescinded (voided) back to the Effective Date of your policy or a claim to be denied.

2. **Time limit on certain defenses:**

   a. We may rescind (void) this policy or deny a claim for Loss incurred within 2 years from your policy Effective Date because of misstatement in your application.

   b. We may rescind (void) your policy or deny a claim for Loss incurred any time after 2 years from your policy's Effective Date only for fraudulent misstatement in your application.

GRACE PERIOD: A grace period of 31 days from your Premium Due Date will be allowed for late payment of premium. During such grace period, this policy will not lapse as long as you pay your full premium before the end of the grace period.

REINSTATEMENT: If any premium is not paid within the time your payment is due, a subsequent acceptance of premium by us or by any agent authorized by us to accept such premium, without requiring an application for reinstatement, shall reinstate your policy. However, if we or our agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, your policy will be reinstated only upon approval of the application by us or, lacking such approval, upon the 45th day following the date of the conditional receipt, unless we have previously notified you in writing of our disapproval of your application. If the application for reinstatement is disapproved, any premium received will be returned to you. If the application for reinstatement is approved, the reinstated policy will cover only Loss resulting from Injury or Sickness sustained after the Effective Date of reinstatement. In all other respects, you and the company shall have the same rights under this policy as were in effect before it lapsed, subject to the provisions of any rider which may be attached in connection with the reinstatement.

NOTICE OF CLAIM: Written notice of claim must be given to the company within twenty days after the beginning of any Loss covered by this policy. If notice cannot be given within that period, it must be given as soon as is reasonably possible. The notice will be considered sufficient if it identifies you and is given to the company at its Home Office or to any authorized agent of the company.

CLAIM FORMS: The company, after receiving notice of claim, will furnish to the claimant forms for filing proof of Loss. If forms are not furnished within 15 days after the giving of such notice, the claimant will be considered to have met the requirements of this policy for proof of Loss if the company is furnished proof of Loss as stated below.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this policy will be paid promptly after the company receives suitable written proof of Loss.

PROOF OF LOSS: Written proof of Loss must be sent to the company at its Home Office within 90 days after the date of Loss. Failure to furnish proof within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

PAYMENT OF CLAIMS: All benefits are payable to you unless we receive proof of an assignment of benefits to pay your health care provider. At your death, any accrued benefits unpaid, and which are not assigned, or unearned premium will be paid to your estate.

REFUND OF UNEARNED PREMIUM UPON DEATH OF INSURED: The company shall refund any premium paid for the period beyond the end of the policy month in which the death occurred. Unearned premium shall be paid in a lump sum to your estate no later than 30 days after receipt of proof of death is received by the company.

PHYSICAL EXAMINATIONS AND AUTOPSY: We, at our expense, shall have the right and opportunity to have a Physician examine you when and as often as we may reasonably require while a claim is pending under your policy, and to request an autopsy in case of death where it is not prohibited by law.

LEGAL ACTION: No action at law or in equity can be brought to recover on this policy until 60 days after written proof of Loss has been given to the company. No action can be brought after 3 years from the date written proof of Loss is required.

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its Effective Date, is in conflict with the statutes of the state in which you reside on such date is automatically changed to meet the minimum requirements of such statutes.

ASSIGNMENT: No assignment of interest under this policy will be binding upon the company unless notice of the assignment is received at the Home Office of the company. The company does not assume any responsibility for the assignment's validity.

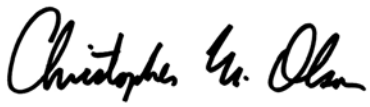
MISSTATEMENT OF AGE OR GENDER: If your age or gender has been misstated in your application for this policy, your premium will be adjusted based on your correct age or gender upon reasonable notice to you. If based on your true age this policy would not have been issued, we will be liable only for the refund of premiums paid for this policy.

UNPAID PREMIUMS: When benefits are paid for a claim under this policy, any premium due and unpaid may be deducted, at our option, from the benefits payable.

EXTENSION OF BENEFITS: Termination of your policy shall be without prejudice to any continuous Loss which commenced while your policy was in force, but the extension of benefits beyond the period that your policy was in force is: (a) subject to your continuous total disability; (b) limited to the duration of the Medicare Benefit Period or, if none is applicable, payment of the maximum benefits; and (c) limited to the covered Injury or Sickness causing the continuous loss beginning while your policy was in force. Receipt of Medicare Part D benefits will not be considered in determining a continuous Loss.

TERM OF COVERAGE: Your coverage starts on the Effective Date at 12:01 A.M. where you live. It ends at 12:01 A.M. where you live on the termination date as described in the Policy Termination section.

IN WITNESS WHEREOF, American Continental Insurance Company has caused this policy to be signed and attested by its authorized Company Officers.



President

Secretary

AMERICAN CONTINENTAL INSURANCE COMPANY

HOME OFFICE
101 Continental Place
Brentwood, Tennessee 37027
Telephone: 1-800-264-4000

MEDICARE SUPPLEMENT POLICY

THIS IS A PLAN "G"

If you need information or have any questions regarding your policy, please contact:

Policyholder Services
P. O. Box 2368
Brentwood, Tennessee 37024-1188
(800) 264-4000

AMERICAN CONTINENTAL INSURANCE COMPANY

HOME OFFICE
101 Continental Place
Brentwood, Tennessee 37027
Telephone: 1-800-264-4000

PREMIUMS ARE SUBJECT TO CHANGE
MEDICARE SUPPLEMENT POLICY – PLAN N

THIS POLICY PROVIDES BENEFITS FOR LOSS DUE TO INJURY OR SICKNESS AS HEREIN LIMITED AND PROVIDED.

Notice to buyer: This policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review all policy limitations.

In this policy the person insured is also called "you" or "your". American Continental Insurance Company is called "us", "we", "our", or "the company." The Definitions section defines other words and terms used in this policy.

In consideration of your payment of the required premiums for this policy, the company insures you against Loss caused by Injury or Sickness as herein limited and provided. Coverage is provided subject to the terms of this policy. The amount of the initial premium and the Effective Date of your policy are shown on the Policy Schedule. This policy is a legal contract between you and the company. READ YOUR POLICY CAREFULLY.

RIGHT TO EXAMINE POLICY FOR THIRTY (30) DAYS: You have 30 days after receipt of this policy to examine its provisions. During that 30-day period, if you are dissatisfied with the policy, it may be returned to the company at its Home Office, to any state office of the company or to the agent from whom it was purchased. Immediately upon such return, this policy shall be void from the beginning and any premium paid will be refunded.

GUARANTEED RENEWABLE: You have the right to renew this policy, for consecutive terms, by paying the required premium before the end of each grace period. You have the right to renew this policy regardless of changes in your physical, mental or health conditions.

PREMIUM AGREEMENT: On each annual anniversary of your Effective Date, premiums for this policy may be changed if there is any change in rates for this policy. Any change in premium will apply to all covered persons with your same policy type based on the issue state of your policy. For any premium change under this paragraph, we will give you at least 30 days advance notice in writing of such premium change.

CHANGE IN BENEFITS: Your benefits will change automatically to correspond with changes in Medicare.

IMPORTANT NOTICE

Please read the copy of your application attached to your policy. Omissions or misstatements in your application could cause a claim to be denied or your policy rescinded. If your policy is rescinded, it will be voided back to its Effective Date and you will have no insurance coverage under your policy. Carefully check your application and write to the Home Office within 10 days of the receipt of your policy if any information shown on it is not correct and complete or if any past medical history is left out of your application. Your application is part of your policy and your policy was issued on the basis that the answers to all questions and information shown on your application are correct and complete.

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American Continental Insurance Company
POLICY SCHEDULE

PLAN N

INSURED: [John Doe] AGE: [65] GENDER: [Male]

ADDRESS: [123 Main St.
Anytown, USA xxxxx]

POLICY NUMBER: [050-10-9999X] POLICY EFFECTIVE DATE: [01/01/10]

INITIAL PREMIUM: [$495.00] PREMIUM MODE: [ANNUAL]

MEDICARE (PART A) - HOSPITAL SERVICES

DAILY BENEFIT NOT COVERED BY MEDICARE:	THIS POLICY PAYS
FIRST 60 DAYS (Part-A Deductible per Benefit Period) .....;.....	100%
61ST TO 90TH DAY (Part A Coinsurance per Benefit Period).....	100%
91ST TO 150TH DAY (Part A Coinsurance for 60 Lifetime Inpatient Reserve Days)	100%
151ST TO 515TH DAY …….. (limited to a lifetime maximum of 365 days and payable at the same rate Medicare would have paid had Medicare Part A Hospital days not been exhausted)	100%

SKILLED NURSING FACILITY CARE:	
FIRST 20 DAYS ……	0%
21ST THRU 100TH DAY, AMOUNT NOT PAID BY MEDICARE ……	100%

BLOOD TRANSFUSIONS (First three (3) Pints - Part A or B)	100%
REMAINDER OF MEDICARE APPROVED AMOUNT AFTER DEDUCTIBLE	20%

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

MEDICAL EXPENSES APPROVED BY MEDICARE:	
PART B DEDUCTIBLE AMOUNT OF MEDICARE APPROVED AMOUNTS	0%
REMAINDER OF MEDICARE APPROVED AMOUNTS ..... (except for up to $20 per office visit and up to $50 per emergency room visit)	20%
PART-B EXCESS CHARGES ABOVE MEDICARE APPROVED AMOUNTS	0%

PARTS A & B

HOME HEALTH CARE, MEDICARE APPROVED SERVICES:	
DURABLE MEDICAL EQUIPMENT, PART B DEDUCTIBLE AMOUNT OF MEDICARE APPROVED AMOUNTS ……...	0%
REMAINDER OF MEDICARE APPROVED AMOUNTS AFTER DEDUCTIBLE....	20%

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL:	
FIRST $250 EACH CALENDAR YEAR ……	0%
REMAINDER OF CHARGES (LIFETIME MAXIMUM BENEFIT $50,000) ……	80%

To Inquire About Your Coverage, or to Express a Concern, Call us Toll-Free at:
Policyholder Services: [1-800-XXX-XXXX]
Claims Customer Service: [1-800-XXX-XXXX]
or Write to Us at:
American Continental Insurance Company
P. O. Box 2368
Brentwood, Tennessee 37027-2368

DEFINITIONS

Shown below are the defined terms used in your policy. These terms are capitalized wherever they appear in the policy.

ACCIDENT means accidental bodily Injury or Injuries causing Loss under this policy. Such Injuries must be caused directly and independent of disease or bodily infirmity or any other cause.

BENEFIT PERIOD means a Benefit Period as defined by Medicare.

COMPANY OFFICER means the President or Secretary.

EFFECTIVE DATE means the date your policy coverage begins at 12:01 A.M. where you live. Your policy Effective Date is listed on the policy schedule page.

HOSPITAL means Hospital as defined by Medicare.

INPATIENT HOSPITAL DEDUCTIBLE means the initial amount of Hospital expenses you incur in a Medicare Benefit Period as a resident bed patient under Medicare Part A. Medicare establishes the amount of the Inpatient Hospital Deductible. Medicare does not pay this amount.

INJURY or INJURIES means bodily Injury caused by an Accident and resulting directly and independently of all other causes.

LIFETIME INPATIENT RESERVE DAYS means additional days that Medicare will pay for when you are confined to a Hospital for more than 90 days in a Benefit Period.
.

LOSS means the incurring of Medicare Eligible Expenses while this policy is in force.

MATERIAL INFORMATION means a condition or combination of conditions you were requested to disclose on the application were not disclosed and which, if disclosed, would have required a different premium or caused us to deny issuing your policy.

MEDICALLY NECESSARY means that the service or supply is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and must:

1. Be prescribed by a Physician;
2. Be consistent with the diagnosis and treatment of such Injury or Sickness;
3. Be in accordance with the generally accepted standards of medical practice; and
4. Not be solely for the convenience of the Insured or the Physician.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965 as then constituted or later amended.

MEDICARE COINSURANCE means the portion of charges covered but not reimbursed by Medicare, excluding the Medicare deductibles, for which you are responsible.

MEDICARE ELIGIBLE EXPENSES means health care expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

MEDICARE PART B DEDUCTIBLE means the amount you must pay each calendar year before benefits will be paid under Medicare Part B. Medicare establishes the amount of the Part B Deductible. Medicare does not pay this amount. A calendar year begins on January 1, and ends on December 31.

PHYSICIAN means a Physician as defined by Medicare.

PREMIUM DUE DATE means the month and day your policy's premium payment is due. The frequency of the Premium Due Date can vary depending on whether your premiums are paid on a monthly, quarterly, semiannual, or annual basis.

RESPITE CARE means treatment that meets Medicare's definition of respite care.

SICKNESS means illness or disease which first manifests itself after your policy's Effective Date and while your policy is in force.

SKILLED NURSING FACILITY means a Skilled Nursing Facility as defined by Medicare.

WRITTEN NOTIFICATION means written notice that you are currently receiving medical assistance or that your medical assistance received has terminated. This notification should include: Insured's name, policy number, copy of the document which indicates the date you became eligible for medical assistance or a copy of the document which indicates the date medical assistance terminated.

Notice must be given by or on behalf of the Insured or the beneficiary to the Home Office, Attn: Policyholders Service Department, or to any authorized agent of the company.

BENEFIT PROVISIONS

BASIC ("CORE") BENEFITS

TO SUPPLEMENT BENEFITS UNDER PART A OF MEDICARE:

1. We will pay all Part A Medicare Coinsurance for inpatient Hospital confinement to the extent not covered by Medicare from the 61st day through 90th day in any Medicare Benefit Period.

2. We will pay all Part A Medicare Coinsurance incurred for each Lifetime Inpatient Reserve Day to the extent not covered by Medicare. Lifetime Inpatient Reserve Days are nonrenewable and limited to 60 days during your lifetime.

3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the Lifetime Inpatient Reserve Days, we will pay one hundred percent of the Part A Medicare Eligible Expenses for inpatient Hospital confinement. Benefits are payable at the same rate Medicare would have paid had Medicare Part A Hospital days not been exhausted. Medicare exhaustion benefits are limited to a lifetime maximum of 365 days of inpatient Hospital confinement.

4. We will pay under Medicare Parts A and B the reasonable cost of the first three 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

5. We will pay the co-payment/coinsurance amount for all Part A Medicare Eligible Expenses for hospice care and Respite Care.

TO SUPPLEMENT BENEFITS UNDER PART B OF MEDICARE:

1. We will pay all of the Medicare Coinsurance amount, or in the case of hospital outpatient department services, paid under a prospective payment system, the copayment amount of Medicare Part B eligible Expenses regardless of Hospital confinement, subject to the Medicare Part B Deductible.

ADDITIONAL BENEFITS

TO SUPPLEMENT BENEFITS UNDER PART A OF MEDICARE:

1. We will pay one hundred percent (100%) of the Medicare Part A Inpatient Hospital Deductible amount per Benefit Period.

2. We will pay for the actual billed charges up to the Medicare Coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-hospital Skilled Nursing Facility care eligible under Medicare Part A. Such confinement must:

    a. begin on or after the Effective Date and while your coverage is in force;
    b. begin within 30 days following a Hospital confinement of 3 days or more;
    c. be for the same Injury or Sickness which required the Hospital confinement; and
    d. be under the direct and personal supervision of a Physician.

TO SUPPLEMENT BENEFITS UNDER PART B OF MEDICARE:

1. We will pay:

    a. the lesser of twenty dollars ($20) or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit (including visits to medical specialists); and

    b. the lesser of fifty dollars ($50) or the Medicare Part B coinsurance or co-payment for each covered emergency room visit, however, this co-payment shall be waived if you are admitted to any Hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

2. We will pay, to the extent not covered by Medicare, 80% of the billed charges for Medicare Eligible Expenses for Medically Necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit “emergency care” shall mean care needed immediately because of an Injury or Sickness of sudden and unexpected onset.

CHANGES IN MEDICARE COINSURANCE AND DEDUCTIBLES

Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

EXCLUSIONS

We will not pay for:

1. Loss incurred while your policy is not in force, except as provided in the Extension of Benefits section of your policy;
2. Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force;
3. That portion of any Loss incurred which is paid for by Medicare;
4. Services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take-home drugs and eye refractions;
5. Services for which a charge is not normally made in the absence of insurance;
6. Loss that is payable under any other Medicare supplement insurance policy or certificate; or
7. Loss that is payable under any other insurance which paid benefits for the same Loss on an expense incurred basis.

RECEIPT OF MEDICAL ASSISTANCE

Benefits and premium(s) under this policy shall be suspended upon your request for any period, (that may be provided by law), in which you have applied for and qualified for the receipt of medical assistance under Title XIX of the Social Security Act (Medicaid), but **only** if you notify us within ninety (90) days after the date you became entitled to such assistance.

If such suspension occurs and if you lose entitlement to such medical assistance, this policy shall be automatically reinstituted, effective as of the date of termination of such entitlement, if you provide Written Notification of loss of such entitlement within ninety (90) days after the date of such loss of entitlement and pay the premium attributable to this period, effective as of the date of termination of such entitlement.

Benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if you lose coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if you provide notice of loss of coverage within 90 days after the date of loss.

If such reinstitution occurs:

1. Your policy shall not provide for any waiting period with respect to treatment of Pre-Existing Conditions;

2. Your benefits provided under the reinstitution will be substantially the same as the benefits in effect before the date of such suspension; and

3. Your premium classification terms provided under the reinstitution will be at least as favorable to you as the premium terms that would have applied had this policy not been suspended.

POLICY TERMINATION

Your policy will terminate on the earliest of:

1. The date we receive your written request to cancel your policy (in which case the grace period will not apply);
2. The date your policy is replaced by another Medicare supplement or Medicare Select policy or by a Part C Medicare Advantage plan (in which case the grace period will not apply);
3. The Premium Due Date, if sufficient premium has not been paid before the end of the grace period; or
4. The date and time of your death.

In the event of cancellation or death, we will promptly return the unearned portion of any premium paid.

POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES: This policy, the application and any attached papers constitute the entire contract. No one has the authority to change this policy or to waive any of its provisions unless the change is approved in writing by a Company Officer. The approval must be written on or attached to this policy.

TIME LIMIT ON CERTAIN DEFENSES:

1. **Misstatement in your application:** We issued your policy based on information we were provided on your application. Any incorrect or omitted Material Information in your application may cause your policy to be rescinded (voided) back to the Effective Date of your policy or a claim to be denied.

2. **Time limit on certain defenses:**

   a. We may rescind (void) this policy or deny a claim for Loss incurred within 2 years from your policy Effective Date because of misstatement in your application.

   b. We may rescind (void) your policy or deny a claim for Loss incurred any time after 2 years from your policy's Effective Date only for fraudulent misstatement in your application.

GRACE PERIOD: A grace period of 31 days from your Premium Due Date will be allowed for late payment of premium. During such grace period, this policy will not lapse as long as you pay your full premium before the end of the grace period.

REINSTATEMENT: If any premium is not paid within the time your payment is due, a subsequent acceptance of premium by us or by any agent authorized by us to accept such premium, without requiring an application for reinstatement, shall reinstate your policy. However, if we or our agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, your policy will be reinstated only upon approval of the application by us or, lacking such approval, upon the 45th day following the date of the conditional receipt, unless we have previously notified you in writing of our disapproval of your application. If the application for reinstatement is disapproved, any premium received will be returned to you. If the application for reinstatement is approved, the reinstated policy will cover only Loss resulting from Injury or Sickness sustained after the Effective Date of reinstatement. In all other respects, you and the company shall have the same rights under this policy as were in effect before it lapsed, subject to the provisions of any rider which may be attached in connection with the reinstatement.

NOTICE OF CLAIM: Written notice of claim must be given to the company within twenty days after the beginning of any Loss covered by this policy. If notice cannot be given within that period, it must be given as soon as is reasonably possible. The notice will be considered sufficient if it identifies you and is given to the company at its Home Office or to any authorized agent of the company.

CLAIM FORMS: The company, after receiving notice of claim, will furnish to the claimant forms for filing proof of Loss. If forms are not furnished within 15 days after the giving of such notice, the claimant will be considered to have met the requirements of this policy for proof of Loss if the company is furnished proof of Loss as stated below.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this policy will be paid promptly after the company receives suitable written proof of Loss.

PROOF OF LOSS: Written proof of Loss must be sent to the company at its Home Office within 90 days after the date of Loss. Failure to furnish proof within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

PAYMENT OF CLAIMS: All benefits are payable to you unless we receive proof of an assignment of benefits to pay your health care provider. At your death, any accrued benefits unpaid, and which are not assigned, or unearned premium will be paid to your estate.

REFUND OF UNEARNED PREMIUM UPON DEATH OF INSURED: The company shall refund any premium paid for the period beyond the end of the policy month in which the death occurred. Unearned premium shall be paid in a lump sum to your estate no later than 30 days after receipt of proof of death is received by the company.

PHYSICAL EXAMINATIONS AND AUTOPSY: We, at our expense, shall have the right and opportunity to have a Physician examine you when and as often as we may reasonably require while a claim is pending under your policy, and to request an autopsy in case of death where it is not prohibited by law.

LEGAL ACTION: No action at law or in equity can be brought to recover on this policy until 60 days after written proof of Loss has been given to the company. No action can be brought after 3 years from the date written proof of Loss is required.

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its Effective Date, is in conflict with the statutes of the state in which you reside on such date is automatically changed to meet the minimum requirements of such statutes.

ASSIGNMENT: No assignment of interest under this policy will be binding upon the company unless notice of the assignment is received at the Home Office of the company. The company does not assume any responsibility for the assignment's validity.

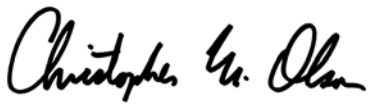
MISSTATEMENT OF AGE OR GENDER: If your age or gender has been misstated in your application for this policy, your premium will be adjusted based on your correct age or gender upon reasonable notice to you. If based on your true age this policy would not have been issued, we will be liable only for the refund of premiums paid for this policy.

UNPAID PREMIUMS: When benefits are paid for a claim under this policy, any premium due and unpaid may be deducted, at our option, from the benefits payable.

EXTENSION OF BENEFITS: Termination of your policy shall be without prejudice to any continuous Loss which commenced while your policy was in force, but the extension of benefits beyond the period that your policy was in force is: (a) subject to your continuous total disability; (b) limited to the duration of the Medicare Benefit Period or, if none is applicable, payment of the maximum benefits; and (c) limited to the covered Injury or Sickness causing the continuous loss beginning while your policy was in force. Receipt of Medicare Part D benefits will not be considered in determining a continuous Loss.

TERM OF COVERAGE: Your coverage starts on the Effective Date at 12:01 A.M. where you live. It ends at 12:01 A.M. where you live on the termination date as described in the Policy Termination section.

IN WITNESS WHEREOF, American Continental Insurance Company has caused this policy to be signed and attested by its authorized Company Officers.



President

Secretary

AMERICAN CONTINENTAL INSURANCE COMPANY

HOME OFFICE
101 Continental Place
Brentwood, Tennessee 37027
Telephone: 1-800-264-4000

MEDICARE SUPPLEMENT POLICY

THIS IS A PLAN "N"

If you need information or have any questions regarding your policy, please contact:

Policyholder Services
P. O. Box 2368
Brentwood, Tennessee 37024-1188
(800) 264-4000

Genworth® Financial

American Continental Insurance Company
A Genworth Financial Company
101 Continental Place
Brentwood, TN 37027

Application for Reinstatement

from American Continental Insurance Company

- Print clearly and use blue or black ink.

1. Insured information

Full name of applicant *First, M.I., Last*

Policy number to be reinstated

Telephone number

1. Within the past 6 months, have you been medically diagnosed, treated, been prescribed medication for, or had surgery for any illness or injury? ○ Yes ○ No
2. Have you been advised by a medical professional to have tests, surgery, treatment or further evaluation for any illness or injury or are there any tests pending? ○ Yes ○ No
3. Are you taking or have you been advised to take any prescribed medications? ○ Yes ○ No

2. Details of "Yes" Answers

Date | Type of injury or illness

Fully recovered? | Doctor/Hospital | Medication taken

Date | Type of injury or illness

Fully recovered? | Doctor/Hospital | Medication taken

Date | Type of injury or illness

Fully recovered? | Doctor/Hospital | Medication taken

Date | Type of injury or illness

Fully recovered? | Doctor/Hospital | Medication taken

3. Applicant

If this policy is reinstated, such reinstatement shall be in accordance with the terms of the policy and shall not take effect until this application for reinstatement has been approved by the Company. If we reject your Reinstatement Application, we will return the monies you submitted with your Reinstatement Application.

I hereby apply to American Continental Insurance Company for reinstatement of my lapsed policy to be reinstated in reliance on my written answers to the questions on this application. I have read and understand all statements and answers and certify that to the best of my knowledge and belief they are true, complete and correctly recorded. I agree that, if my policy is reinstated, such reinstatement shall be in accordance with the terms of the policy and shall not take effect until this application of reinstatement and the premium payment accompanying this application have been accepted and approved by the Company.

It is further agreed that reinstatement of this policy, if granted by the Company, shall be contestable for fraud or misrepresentation of any material facts stated in, or in connection with, this application for two years after the date of reinstatement.

Signature of applicant
X

Date

City

State

Zip

4. Fraud warnings

Arkansas and Louisiana and Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of the insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine and Tennessee and Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy, is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or a deceptive statement is guilty of insurance fraud.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania: Any person who, knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Genworth® Financial

MEDICARE SUPPLEMENT INSURANCE POLICY

HELPING PROVIDE FINANCIAL SECURITY

Underwritten by
American Continental Insurance Company

A Genworth Financial Company

Not connected with or endorsed by the U.S. Government or the Federal Medicare Program

ACIMS001

101309

WELCOME

Dear Valued Policyholder,

Thank you for your recent application for Medicare Supplement insurance and let me welcome you to our family of policyholders. Enclosed is your policy. We would like for you to take a few minutes to look over the copy of your application in the back of your policy. **It is important that all information including your date of birth, height, weight and health questions are answered correctly.** Please pay close attention to the answers on the health and medical questions as an incorrect answer could jeopardize your coverage under this policy. If you applied during the Open Enrollment or Guarantee Issue period, these health questions will not be answered as they do not apply. If there are any corrections or additions please notify us immediately.

American Continental Insurance Company is committed to providing outstanding service to our policyholders. We feel that our rapid growth is a result of striving for excellence through personalized customer service and products to fulfill your needs. Please take a few moments to review your policy and keep it in a handy place for future reference.

If you have any questions regarding your policy benefits or if we can be of assistance in other ways concerning your insurance needs, please let us hear from you. Our staff of dedicated professionals is ready to assist you.

Sincerely,

Christopher M. Olson
President and CEO

OUR COMMITMENT

American Continental Insurance Company, headquartered in Brentwood, Tennessee, has an unwavering commitment to providing the best personal service possible, quick claims payment, quality products with solid financial backing, and helpful, friendly associates with extensive knowledge and experience. Policyholders rely on our company to be there when they need us. We take those obligations very seriously and everything we do is focused on fulfilling our commitments in a timely, hassle-free manner – so you have the best experience possible.

American Continental
Insurance Company
A Genworth Financial Company
101 Continental Place
Brentwood, Tennessee 37027
800 264.4000
cont-life.com
genworth.com

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INSURANCE MARKETPLACE
STANDARDS ASSOCIATION

American Continental Insurance Company
[Home Offices: Brentwood, Tennessee]

AMENDMENT

«Name»
«Address_1»
«Address_2»
«City»

Amendment to ☒ Policy ☐ Application of «Name» (Name of Applicant or Insured)

Dated «date» (Month) (Day) (Year) Policy Number «POLICY»

The above captioned : ☒ Policy ☐ Application shall be amended as follows:

THE PROVISION ATTACHED IS ADDED TO YOUR INSURANCE COVERAGE.

[date of birth added or corrected]

This Amendment shall not, except as stated above, waive, alter, extend or otherwise amend, any of the conditions, provisions or agreements of this Policy. With respect to application amendments as designated above, it is agreed that such amendments (a) shall be a part of the application as fully as if made in such application, and (b) shall amend and supersede any inconsistent statements in such application.

This Amendment shall be effective: check either (a) or (b)

☐ (a) upon Acceptance as indicated by signature below; or

☒ (b) 01 (Month) 01 (Day) 96 (Year) (Acceptance signature not required)

American Continental Insurance Company

President

Secretary

ACCEPTANCE: If required by (a) above

N/A
Signature of

☐ Insured or Proposed Insured
☐ Applicant/Owner if other than Proposed Insured

Date: N/A (Month) (Day), 20 (Year)

PAF 12/09

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Accepted for Informational Purposes	03/10/2010

Comments:

Attachment:

AR CERT OF READABILITY.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved	03/10/2010

Comments:

Attachment:

ACIMS0341AR APPLICATION.pdf

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved	03/10/2010

Comments:

Attachment:

ACIMS0358AR.pdf

CERTIFICATE OF READABILITY

I certify that the forms listed below have received a Flesch Readability Score as indicated below.

Company Officer Signature

Steven L. Hendrich
Company Officer Name

Secretary
Company Officer-Title

January 15, 2010
Date

Form Number	Readability Score
ACIMSP10A	45.5
ACIMSP10B	45.4
ACIMSP10F	45.3
ACIMSP10HF	45.3
ACIMSP10G	45.7
ACIMSP10N	45.4

Genworth®
Financial

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

APPLICATION

MEDICARE SUPPLEMENT INSURANCE

Underwritten by
American Continental Insurance Company

Arkansas

ACIMS0341AR 121809
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Genworth® Financial

American Continental Insurance Company
A Genworth Financial Company
101 Continental Place
Brentwood, TN 37027

Application for Medicare Supplement Insurance
from American Continental Insurance Company

• Print clearly and use blue or black ink.

1. Proposed insured information

Write the name as stated on the Medicare card. Provide a copy of the Medicare card with the application if possible.

Full name of proposed insured *First, M.I., Last*

Address

Phone

City

State

Zip

E-mail

Social Security Number

Write the date of birth that is on the birth certificate.

Birth date *mm/dd/yyyy*

Age

Height *Feet and inches*

Weight *Pounds*

○ Male
○ Female

Are you a legal resident of the United States? ○ Yes ○ No

Have you used any form of tobacco in the past 12 months? ○ Yes ○ No

Include any letters associated with the Medicare number and in the appropriate position. If applicant has not received a Medicare card yet, put "No Medicare number yet".

Medicare card number

Date enrolled in: Medicare Part A Medicare Part B

For Agent Use Only:

Check one if application is for: ○ Open Enrollment ○ Guaranteed Issue

2. Plan and premium information

Plan selected:

Requested Medicare Supplement effective date *mm/dd/yyyy*

You have a choice among several payment options or modes for paying your premium (annual, semi-annual, quarterly and monthly electronic funds transfer).

Annual premium:
$

Payment mode
○ Annually ○ Quarterly
○ Semi-Annually ○ Monthly EFT (Electronic Funds Transfer)

Modal premium:
$

Policy fee:
$

Total modal premium collected/draft:
$

PAYMENT MODES

Each payment mode, other than annual and monthly electronic funds transfer, results in higher total yearly premium costs. Reasons for higher costs include added collection and administrative costs, time value of money considerations and lapse rates. The annual and monthly electronic funds transfer modes have the same and lowest total yearly premium costs. As a result, there is a time value of money advantage to you for paying monthly versus annually. However, there may be other advantages to you for choosing an annual payment based on your preferences. Your agent can explain the differences in modes and help you decide which is best for you. You may change your payment mode, among the modes available, during the life of your policy.

Applicant Initials .....

3. Eligibility questions

Please answer all questions.

To the best of your knowledge:

1. Did you turn age 65 in the last 6 months? ○ Y ○ N
   A. Did you enroll in Medicare Part B in the last 6 months? ○ Y ○ N
   B. If yes, what is the effective date?
   . / /

NOTE: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to question 2.

2. Are you covered for medical assistance through the state Medicaid program? ○ Y ○ N
   A. If yes: Will Medicaid pay your premiums for this Medicare Supplement policy? ○ Y ○ N
   B. Do you receive any benefits from Medicaid **other than** payments toward your Medicare Part B premium? ○ Y ○ N

3. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "End" blank.
   Start date . / / End date . / /
   A. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ○ Y ○ N
   B. Was this your first time in this type of Medicare plan? ○ Y ○ N
   C. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ○ Y ○ N

4. Do you have another Medicare Supplement policy inforce? ○ Y ○ N
   A. If so, with what company, and what plan do you have?
   Company . Plan .
   B. If so, do you intend to replace your current Medicare Supplement policy with this policy? ○ Y ○ N

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) ○ Y ○ N
   A. If so, with what company, and what kind of policy?
   Company . Plan .
   B. What are your start and end dates of coverage under the other policy? (If you are still covered under the other policy, leave "End" blank.)
   Start date . / / End date . / /

Applicant Initials .....

4. Health questions

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

If the health questions are answered for an Open Enrollment or Guaranteed Issue application, the application cannot be processed and will be returned.

If any health questions are answered "yes" in Section 4, the applicant does not qualify for this insurance with us.

1. Are you dependent on a wheelchair or any motorized mobility device?	○ Y	○ N
2. Do any of the following apply to you?		
Currently hospitalized, confined to a bed, in a nursing facility or assisted living facility, receiving home health care or physical therapy	○ Y	○ N
3. At any time, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. congestive heart failure, unoperated aneurysm, defibrillator	○ Y	○ N
B. leukemia, lymphoma, multiple myeloma, cirrhosis	○ Y	○ N
C. Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia, multiple sclerosis, muscular dystrophy, cerebral palsy	○ Y	○ N
D. chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency, Addison's Disease	○ Y	○ N
E. any condition requiring a bone marrow transplant or stem cell transplant, any condition requiring an organ transplant	○ Y	○ N
F. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV)	○ Y	○ N
4. Do you have diabetes?		
A. that requires use of insulin	○ Y	○ N
B. with complications including retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage	○ Y	○ N
C. with history of heart attack or stroke (at any time)	○ Y	○ N
D. treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar	○ Y	○ N
5. Within the past 36 months, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. alcoholism, drug abuse	○ Y	○ N
B. cardiomyopathy, atrial fibrillation, anemia requiring repeated blood transfusions, any other blood disorder	○ Y	○ N
C. internal cancer, melanoma, Hodgkin's Disease	○ Y	○ N
D. hepatitis, disorder of the pancreas	○ Y	○ N
6. Within the past 24 months, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. enlarged heart, transient ischemic attack (TIA), stroke, peripheral vascular or arterial disease, neuropathy, amputation caused by disease	○ Y	○ N
B. myasthenia gravis, systemic lupus or connective tissue disorder	○ Y	○ N
C. osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living	○ Y	○ N
D. any lung or respiratory disorder requiring the use of a nebulizer or oxygen, or 3 or more medications for lung or respiratory disorder	○ Y	○ N
E. any lung or respiratory disorder and currently use tobacco products	○ Y	○ N
7. Within the past 12 months, have you been advised by a medical professional to have treatment, further evaluation, diagnostic testing, or any surgery that has not been performed?	○ Y	○ N
8. Within the past 12 months, have you been medically diagnosed or, treated, or had surgery for a heart attack, artery blockage, or heart valve disorder?	○ Y	○ N

9. Within the past 12 months, do any of the following apply to you?
   - A. had a pacemaker implanted ○ Y ○ N
   - B. had a PSA blood test greater than 4.5, under age 70, with no history of prostate cancer ○ Y ○ N
   - C. had a PSA blood test greater than 6.5, age 70 or older, with no history of prostate cancer ○ Y ○ N
   - D. had a seizure ○ Y ○ N
10. Was your last blood pressure reading higher than 175 Systolic or higher than 100 Diastolic? ○ Y ○ N

Systolic is the upper number and Diastolic is the bottom number of a blood pressure reading.

5. Health history

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

1. Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide reason and diagnosis:

2. Within the past five years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide reason and diagnosis:

3.

Prescribed medications	**Reason for medications (diagnosis)**

Use an additional sheet of paper if needed for explanation.

6. Physician information

Your primary physician Phone

Physician's office name

City State

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Specialist seen in the past 24 months Specialty

Reason for seeing (diagnosis)

Have you seen any additional physicians other than those listed above in the past 24 months? ○ Y ○ N

7. Important statements

1. You do not need more than one Medicare Supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

8. Privacy notice

Although your application is our initial source of information, we may collect information, including health history and medical records, from persons other than you and we may conduct a telephone interview with you. American Continental Insurance Company, its affiliates, or its reinsurer(s) may also in certain circumstances release information collected by us to third parties without authorization from you. Upon written request, we will provide you with the information contained in your file. Medical information will be disclosed to you only through the medical professional you designate. Should you wish to request correction, amendment or deletion of any information in your file, which you believe inaccurate, please contact us and we will advise you of the necessary procedures.

9. Producer compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums and delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our companies, or for the percentage of completed sales. (Generally, this will not be the case for registered variable insurance products or for fixed products sold through banks or broker-dealers.) Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

10. Applicant agreement

I hereby apply to American Continental Insurance Company for a policy to be issued in reliance on my written answers to the questions on this application. I have read and understand all statements and answers and certify that to the best of my knowledge and belief, they are true, complete and correctly recorded. I acknowledge that I have received an outline of coverage for the policy applied for and *A Guide to Health Insurance for People with Medicare*.

I agree (1) this application and any policy issued will constitute the entire contract of insurance and the Company will not be bound in any way by any statements, promises or information made or given by or to any agent or other person at any time unless the same is in writing and submitted to the Company at its Home Office and made a part of such contract. Only a Company Officer can make, modify or discharge contracts or waive any of the Company's rights or requirements and then only in writing; and (2) the policy shall not be effective until it has actually been issued by the Company and said policy is manually received and accepted by me and the first premium paid, and there has been no change in my health as stated in the application.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

I understand that if any answers on this application are incorrect, incomplete or untrue, American Continental Insurance Company has the right to adjust my premium, reduce my benefits or rescind the policy.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information on an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Applicant signature Date signed

X .

11. Account information

Complete this section if you are requesting electronic funds transfer (EFT) for premium payment.

Include a voided check with the application.

Proposed insured's name

Account owner name, if different than proposed insured's

Account owner relationship to proposed insured:
- ○ Business owned by proposed insured
- ○ Living trust
- ○ Employer
- ○ Power of Attorney
- ○ Conservator/guardian
- ○ Family member; specify

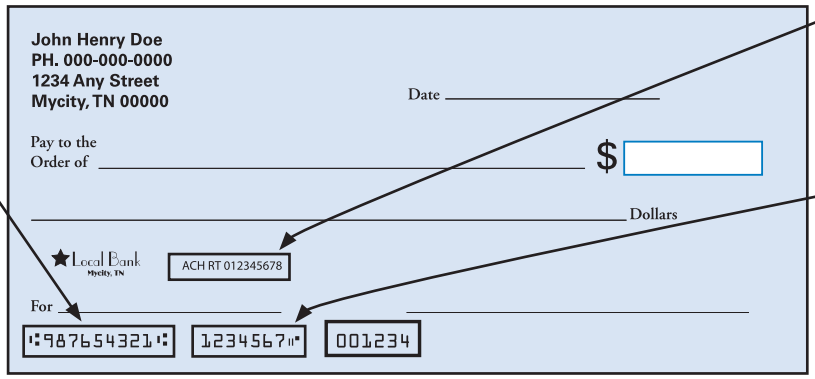
Financial institution name

○ Checking ○ Savings

Routing number

Account number

This is an example of a personal check. A business check may be different.



For checks with an **ACH RT (Automated Clearing House Routing) number**, please use this number.

The **account number** is up to 17 characters long and appears next to the ⑈ symbol at the bottom of the check and usually to the right of the bank routing number.

For all other checks, use the nine-character bank **routing number**, which appears between the ⑆ symbols, usually at the bottom left corner of the check.

12. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

Signature only required if the account owner is different than the proposed insured.

Signature of account owner **X** Date

13. Agent

All information **must** be completed.

Please list any other medical or health insurance policies sold to the proposed insured.

1) List policies sold which are still in force

- .....
- .....

2) List policies sold in the past 5 years which are no longer in force

- .....
- .....

I certify that:

1. I have accurately recorded the information supplied by the applicant.
2. The application was provided to the applicant to review and the applicant has been advised that any false statement or misrepresentation in the application may result in an adjustment of premium, reduction of benefits or rescission of the policy.
3. I have provided an outline of coverage for the policy applied for and *A Guide to Health Insurance for People with Medicare* to applicant prior to completing the application.

The writing number reflects where commissions will be paid.

Agent name *Printed*	Writing number (agent or company)
.	.
Agent signature	State license ID number (for FL only)
X	.
Phone	E-mail
.	.

14. Agent request to split commissions

This section must be completed with this application in order to split commissions.

If this application results in an issued policy through American Continental Insurance Company (ACI), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with ACI in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains inforce.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective ACI commission schedule.

Agent Information *Print*

Writing Agent		Percentage
.		. %
Secondary Agent	Writing number	Percentage
.	.	. %

By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

Writing Agent Signature

X .....

Genworth® Financial

American Continental Insurance Company
A Genworth Financial Company
101 Continental Place
Brentwood, TN 37027

800 264.4000
cont-life.com
office hours 7:30 a.m. - 4:30 p.m. CST

Receipt
from American Continental Insurance Company

- Print clearly and use blue or black ink.
- Applicant keeps this receipt for their records.

Proposed insured's name *Printed*

Date of application

Initial payment collected (if applicable)
$

○ Check ○ Money order

EFT draft amount
$

This acknowledges receipt of your application for an American Continental Insurance Company Medicare Supplement insurance policy.

Agent name *Printed*

Phone

Signature of agent
X

- Payment will be refunded for any coverage not issued.
- All premium payments must be made payable to American Continental Insurance Company.
- DO NOT make any check payable to the agent and do not leave the payee blank on the check.
- A recorded interview may be required as part of the underwriting on your application for insurance.

Medicare Supplement Insurance - A. If this payment equals the full, initial premium for the mode of premium payment selected by the applicant; and B. if the answers are true and correct in the application and if American Continental Insurance Company issues a Medicare Supplement policy according to its rules, limits, and standards for the plan and amount applied for by the applicant; then this payment shall be applied to the payment of the first premium of the issued Medicare Supplement policy. No Medicare Supplement policy shall be effective until it has actually been issued by American Continental Insurance Company.

Thank you for choosing American Continental Insurance Company!

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Genworth Financial

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

OUTLINE OF COVERAGE

MEDICARE SUPPLEMENT INSURANCE

BENEFIT PLANS

Underwritten by
American Continental Insurance Company

Arkansas

AMERICAN CONTINENTAL INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 2
BENEFIT PLANS AVAILABLE: A, B, F, HIGH DEDUCTIBLE F, G, N

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

Plans E, H, I and J are no longer available for sale.

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 50%	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	Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $[4140]; paid at 100% after limit reached	Out-of-pocket limit $[4140]; 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 [$2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$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.

American Continental Insurance Company
Arkansas Individual Premium Rates
PLAN A

Zip Codes beginning with 722

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1,490.00	774.80	394.85	124.12	1,656.00	861.12	438.84	137.94

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1,490.00	774.80	394.85	124.12	1,656.00	861.12	438.84	137.94

All other Zip Codes beginning with 720 and 721

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1,263.00	656.76	334.70	105.21	1,404.00	730.08	372.06	116.95

Rest of State (Zip Codes not listed above)

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1,192.00	619.84	315.88	99.29	1,325.00	689.00	351.13	110.37

American Continental Insurance Company
Arkansas Individual Premium Rates
PLAN B

Zip Codes beginning with 722

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1877.00	976.04	497.41	156.35	2086.00	1084.72	552.79	173.76

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1877.00	976.04	497.41	156.35	2086.00	1084.72	552.79	173.76

All other Zip Codes beginning with 720 and 721

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1591.00	827.32	421.62	132.53	1768.00	919.36	468.52	147.27

Rest of State (Zip Codes not listed above)

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1502.00	781.04	398.03	125.12	1669.00	867.88	442.29	139.03

American Continental Insurance Company
Arkansas Individual Premium Rates
PLAN F

Zip Codes beginning with 722

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	2125.00	1105.00	563.13	177.01	2361.00	1227.72	625.67	196.67

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	2125.00	1105.00	563.13	177.01	2361.00	1227.72	625.67	196.67

All other Zip Codes beginning with 720 and 721

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1801.00	936.52	477.27	150.02	2002.00	1041.04	530.53	166.77

Rest of State (Zip Codes not listed above)

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1700.00	884.00	450.50	141.61	1889.00	982.28	500.59	157.35

American Continental Insurance Company
Arkansas Individual Premium Rates
PLAN HF

Zip Codes beginning with 722

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	836.00	434.72	221.54	69.64	928.00	482.56	245.92	77.30

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	836.00	434.72	221.54	69.64	928.00	482.56	245.92	77.30

All other Zip Codes beginning with 720 and 721

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	708.00	368.16	187.62	58.98	787.00	409.24	208.56	65.56

Rest of State (Zip Codes not listed above)

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	669.00	347.88	177.29	55.73	743.00	386.36	196.90	61.89

American Continental Insurance Company
Arkansas Individual Premium Rates
PLAN G

Zip Codes beginning with 722

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1910.00	993.20	506.15	159.10	2122.00	1103.44	562.33	176.76

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1910.00	993.20	506.15	159.10	2122.00	1103.44	562.33	176.76

All other Zip Codes beginning with 720 and 721

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1619.00	841.88	429.04	134.86	1799.00	935.48	476.74	149.86

Rest of State (Zip Codes not listed above)

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1528.00	794.56	404.92	127.28	1698.00	882.96	449.97	141.44

American Continental Insurance Company
Arkansas Individual Premium Rates
PLAN N

Zip Codes beginning with 722

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1516.00	788.32	401.74	126.28	1685.00	876.20	446.53	140.36

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1516.00	788.32	401.74	126.28	1685.00	876.20	446.53	140.36

All other Zip Codes beginning with 720 and 721

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1285.00	668.20	340.53	107.04	1428.00	742.56	378.42	118.95

Rest of State (Zip Codes not listed above)

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1213.00	630.76	321.45	101.04	1348.00	700.96	357.22	112.29

PREMIUM INFORMATION

American Continental Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state. Any change in premium will occur on the first renewal date that coincides with or follows each anniversary of your policy effective date. If we make a change, we will provide you with 30 days advance notice

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. [This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J will no longer be available for sale after May 31, 2010.]

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to American Continental Insurance Company, P.O.Box 2368, Brentwood, Tennessee 37024. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

POLICY REPLACEMENT

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

NOTICE

The policy may not cover all of your medical costs.

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1068]	$0	[$1068] (Part A Deductible)
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but[$534] a day	[$534] 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 [$133.50] a day	$0	Up to[$133.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	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

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
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 [$135] of Medicare-Approved amounts*	$0	$0	[$135] (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 [$135] of Medicare-Approved amounts*	$0	$0	[$135] (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 [$135]of Medicare Approved amounts*	$0	$0	[$135] (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 [$1068]	[$1068] (Part A Deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$534] a day	[$534] 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 [$133.50] a day	$0	Up to [$133.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient 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 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 [[$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
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 [$135] of Medicare-Approved amounts*	$0	$0	[$135] (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 [$135] of Medicare-Approved amounts*	$0	$0	[$135] (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 [$135] of Medicare Approved amounts*	$0	$0	[$135] (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 [$1068]	[$1068] (Part A Deductible)	$0
61st thru 90th day	All but $267 a day	[$267] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$534] a day	[$534] 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[$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient 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 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 [$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
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 [$135] of Medicare-Approved amounts*	$0	[$135] (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 [$135] of Medicare-Approved amounts*	$0	[$135] (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 [$135] of Medicare Approved amounts*	$0	[$135] (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 [$2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$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	All but [$1068]	[$1068] (Part A Deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$534] a day	[$534] 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 [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient 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 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 [$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.

****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 exceed [$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 [$135] of Medicare-Approved amounts*	$0	[$135] (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 [$135] of Medicare-Approved amounts*	$0	[$135] (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 [$2000] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2000] DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First [$135] of Medicare Approved amounts*	$0	[$135] (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	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	$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 [$1068]	[$1068] (Part A Deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$534] a day	[$534] 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 [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	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 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 [$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
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 [$135] of Medicare-Approved amounts*	$0	$0	[$135] (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 [$135] of Medicare-Approved amounts*	$0	$0	[$135] (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 [$135] of Medicare Approved amounts*	$0	$0	[$135] (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN G

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	$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 [$1068]	[$1068] (Part A Deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$534] a day	[$534] 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 [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	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 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 [$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
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 [$135] of Medicare-Approved amounts*	$0	$0	[$135] (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 [$135] of Medicare-Approved amounts*	$0	$0	[$135] (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 [$135] of Medicare Approved amounts*	$0	$0	[$135] (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

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
12/17/2009	Supporting Document	Outline of Coverage	03/10/2010	ACIMS0358AR.pdf (Superceded)
01/27/2010	Form	PLAN A POLICY	03/10/2010	Plan A AR.pdf (Superceded)

Genworth®
Financial

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OUTLINE OF COVERAGE

MEDICARE SUPPLEMENT INSURANCE

BENEFIT PLANS

Underwritten by
American Continental Insurance Company

Arkansas

AMERICAN CONTINENTAL INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 2
BENEFIT PLANS AVAILABLE: A, B, F, HIGH DEDUCTIBLE F, G, N

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

Plans E, H, I and J are no longer available for sale.

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 50%	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	Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $[4140]; paid at 100% after limit reached	Out-of-pocket limit $[4140]; 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 [$2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$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.

American Continental Insurance Company
Arkansas Individual Premium Rates
PLAN A

Zip Codes beginning with 722

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1,490.00	774.80	394.85	124.12	1,656.00	861.12	438.84	137.94

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1,490.00	774.80	394.85	124.12	1,656.00	861.12	438.84	137.94

All other Zip Codes beginning with 720 and 721

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1,263.00	656.76	334.70	105.21	1,404.00	730.08	372.06	116.95

Rest of State (Zip Codes not listed above)

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1,192.00	619.84	315.88	99.29	1,325.00	689.00	351.13	110.37

American Continental Insurance Company
Arkansas Individual Premium Rates
PLAN B

Zip Codes beginning with 722

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1877.00	976.04	497.41	156.35	2086.00	1084.72	552.79	173.76

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1877.00	976.04	497.41	156.35	2086.00	1084.72	552.79	173.76

All other Zip Codes beginning with 720 and 721

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1591.00	827.32	421.62	132.53	1768.00	919.36	468.52	147.27

Rest of State (Zip Codes not listed above)

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1502.00	781.04	398.03	125.12	1669.00	867.88	442.29	139.03

American Continental Insurance Company
Arkansas Individual Premium Rates
PLAN F

Zip Codes beginning with 722

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	2125.00	1105.00	563.13	177.01	2361.00	1227.72	625.67	196.67

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	2125.00	1105.00	563.13	177.01	2361.00	1227.72	625.67	196.67

All other Zip Codes beginning with 720 and 721

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1801.00	936.52	477.27	150.02	2002.00	1041.04	530.53	166.77

Rest of State (Zip Codes not listed above)

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1700.00	884.00	450.50	141.61	1889.00	982.28	500.59	157.35

American Continental Insurance Company
Arkansas Individual Premium Rates
PLAN HF

Zip Codes beginning with 722

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	836.00	434.72	221.54	69.64	928.00	482.56	245.92	77.30

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	836.00	434.72	221.54	69.64	928.00	482.56	245.92	77.30

All other Zip Codes beginning with 720 and 721

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	708.00	368.16	187.62	58.98	787.00	409.24	208.56	65.56

Rest of State (Zip Codes not listed above)

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	669.00	347.88	177.29	55.73	743.00	386.36	196.90	61.89

American Continental Insurance Company
Arkansas Individual Premium Rates
PLAN G

Zip Codes beginning with 722

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1910.00	993.20	506.15	159.10	2122.00	1103.44	562.33	176.76

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1910.00	993.20	506.15	159.10	2122.00	1103.44	562.33	176.76

All other Zip Codes beginning with 720 and 721

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1619.00	841.88	429.04	134.86	1799.00	935.48	476.74	149.86

Rest of State (Zip Codes not listed above)

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1528.00	794.56	404.92	127.28	1698.00	882.96	449.97	141.44

American Continental Insurance Company
Arkansas Individual Premium Rates
PLAN N

Zip Codes beginning with 722

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1516.00	788.32	401.74	126.28	1685.00	876.20	446.53	140.36

Zip Codes 72002, 72053, 72065, 72076, 72078, 72099, 72103, 72113-72120, 72124, 72135, 72142, 72164, 72180, 72183, 72190, 72198, 72199

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1516.00	788.32	401.74	126.28	1685.00	876.20	446.53	140.36

All other Zip Codes beginning with 720 and 721

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1285.00	668.20	340.53	107.04	1428.00	742.56	378.42	118.95

Rest of State (Zip Codes not listed above)

Issue Age	Preferred Rate Annual	Semi	Qtrly	Mthly	Standard Rate Annual	Semi	Qtrly	Mthly
All	1213.00	630.76	321.45	101.04	1348.00	700.96	357.22	112.29

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 may be changed for this policy on any premium due date, provided premiums for all policies issued on this form number in your state are also changed. For every nonscheduled premium change, we will give you at least 30 days advance notice in writing of such premium change.

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. This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J will no longer be available for sale after May 31, 2010.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to American Continental Insurance Company, P.O.Box 2368, Brentwood, Tennessee 37024. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

POLICY REPLACEMENT

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

NOTICE

The policy may not cover all of your medical costs.

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1068]	$0	[$1068] (Part A Deductible)
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but[$534] a day	[$534] 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 [$133.50] a day	$0	Up to[$133.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	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

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
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 [$135] of Medicare-Approved amounts*	$0	$0	[$135] (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 [$135] of Medicare-Approved amounts*	$0	$0	[$135] (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 [$135]of Medicare Approved amounts*	$0	$0	[$135] (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 [$1068]	[$1068] (Part A Deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$534] a day	[$534] 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 [$133.50] a day	$0	Up to [$133.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient 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 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 [[$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
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 [$135] of Medicare-Approved amounts*	$0	$0	[$135] (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 [$135] of Medicare-Approved amounts*	$0	$0	[$135] (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 [$135] of Medicare Approved amounts*	$0	$0	[$135] (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 [$1068]	[$1068] (Part A Deductible)	$0
61st thru 90th day	All but $267 a day	[$267] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$534] a day	[$534] 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[$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient 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 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 [$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
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 [$135] of Medicare-Approved amounts*	$0	[$135] (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 [$135] of Medicare-Approved amounts*	$0	[$135] (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 [$135] of Medicare Approved amounts*	$0	[$135] (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 [$2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$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	All but [$1068]	[$1068] (Part A Deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$534] a day	[$534] 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 [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient 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 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 [$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.

****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 exceed [$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 [$135] of Medicare-Approved amounts*	$0	[$135] (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 [$135] of Medicare-Approved amounts*	$0	[$135] (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	AFTER YOU PAY [$2000] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2000] DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First [$135] of Medicare Approved amounts*	$0	[$135] (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	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	$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 [$1068]	[$1068] (Part A Deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$534] a day	[$534] 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 [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	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 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 [$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
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 [$135] of Medicare-Approved amounts*	$0	$0	[$135] (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 [$135] of Medicare-Approved amounts*	$0	$0	[$135] (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 [$135] of Medicare Approved amounts*	$0	$0	[$135] (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN G

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	$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 [$1068]	[$1068] (Part A Deductible)	$0
61st thru 90th day	All but [$267] a day	[$267] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$534] a day	[$534] 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 [$133.50] a day	Up to [$133.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	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 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 [$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
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 [$135] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	$0 Generally 80%	$0 Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	[$135] (Part B Deductible) Up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-Approved amounts)	$0	0%	All costs
BLOOD First 3 pints Next [$135] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	$0 $0 80%	All costs $0 20%	$0 [$135] (Part B Deductible) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First [$135] of Medicare Approved amounts*	$0	$0	[$135] (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

AMERICAN CONTINENTAL INSURANCE COMPANY

HOME OFFICE
101 Continental Place
Brentwood, Tennessee 37027
Telephone: 1-800-264-4000

PREMIUMS ARE SUBJECT TO CHANGE
MEDICARE SUPPLEMENT POLICY – PLAN A

THIS POLICY PROVIDES BENEFITS FOR LOSS DUE TO INJURY OR SICKNESS AS HEREIN LIMITED AND PROVIDED.

Notice to buyer: This policy may not cover all of the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review all policy limitations.

In this policy the person insured is also called "you" or "your". American Continental Insurance Company is called "us", "we", "our", or "the company." The Definitions section defines other words and terms used in this policy.

In consideration of your payment of the required premiums for this policy, the company insures you against Loss caused by Injury or Sickness as herein limited and provided. Coverage is provided subject to the terms of this policy. The amount of the initial premium and the Effective Date of your policy are shown on the Policy Schedule. This policy is a legal contract between you and the company. READ YOUR POLICY CAREFULLY.

RIGHT TO EXAMINE POLICY FOR THIRTY (30) DAYS: You have 30 days after receipt of this policy to examine its provisions. During that 30-day period, if you are dissatisfied with the policy, it may be returned to the company at its Home Office, to any state office of the company or to the agent from whom it was purchased. Immediately upon such return, this policy shall be void from the beginning and any premium paid will be refunded.

GUARANTEED RENEWABLE: You have the right to renew this policy, for consecutive terms, by paying the required premium before the end of each grace period. You have the right to renew this policy regardless of changes in your physical, mental or health conditions.

PREMIUM AGREEMENT: On each annual anniversary of your Effective Date, premiums for this policy may be changed if there is any change in rates for this policy. Any change in premium will apply to all covered persons with your same policy type based on the issue state of your policy. For any premium change under this paragraph, we will give you at least 30 days advance notice in writing of such premium change.

CHANGE IN BENEFITS: Your benefits will change automatically to correspond with changes in Medicare.

IMPORTANT NOTICE

Please read the copy of your application attached to your policy. Omissions or misstatements in your application could cause a claim to be denied or your policy rescinded. If your policy is rescinded, it will be voided back to its Effective Date and you will have no insurance coverage under your policy. Carefully check your application and write to the Home Office within 10 days of the receipt of your policy if any information shown on it is not correct and complete or if any past medical history is left out of your application. Your application is part of your policy and your policy was issued on the basis that the answers to all questions and information shown on your application are correct and complete.

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American Continental Insurance Company

POLICY SCHEDULE

PLAN A

INSURED: [John Doe] AGE: [65] GENDER: [Male]

ADDRESS: [123 Main St.
Anytown, USA xxxxx]

POLICY NUMBER: [050-10-9999X] POLICY EFFECTIVE DATE: [01/01/10]

INITIAL PREMIUM: [$495.00] PREMIUM MODE: [ANNUAL]

MEDICARE (PART A) - HOSPITAL SERVICES

DAILY BENEFIT NOT COVERED BY MEDICARE:	THIS POLICY PAYS
FIRST 60 DAYS (Part-A Deductible per Benefit Period) .....;.....	0%
61ST TO 90TH DAY (Part A Coinsurance per Benefit Period).....	100%
91ST TO 150TH DAY (Part A Coinsurance for 60 Lifetime Inpatient Reserve Days)	100%
151ST TO 515TH DAY …….. (limited to a lifetime maximum of 365 days and payable at the same rate Medicare would have paid had Medicare Part A Hospital days not been exhausted)	100%
BLOOD TRANSFUSIONS (First three (3) Pints - Part A or B)	100%
REMAINDER OF MEDICARE APPROVED AMOUNT AFTER DEDUCTIBLE	20%

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

MEDICAL EXPENSES APPROVED BY MEDICARE:	
PART B DEDUCTIBLE AMOUNT OF MEDICARE APPROVED AMOUNTS	0%
REMAINDER OF MEDICARE APPROVED AMOUNTS	20%
PART-B EXCESS CHARGES ABOVE MEDICARE APPROVED AMOUNTS	0%

PARTS A & B

HOME HEALTH CARE, MEDICARE APPROVED SERVICES:	
DURABLE MEDICAL EQUIPMENT, PART B DEDUCTIBLE AMOUNT OF MEDICARE APPROVED AMOUNTS ……...	0%
REMAINDER OF MEDICARE APPROVED AMOUNTS AFTER DEDUCTIBLE....	20%

To Inquire About Your Coverage, or to Express a Concern, Call us Toll-Free at:
Policyholder Services: [1-800-XXX-XXXX]
Claims Customer Service: [1-800-XXX-XXXX]
or Write to Us at:
American Continental Insurance Company
P. O. Box 2368
Brentwood, Tennessee 37027-2368

DEFINITIONS

Shown below are the defined terms used in your policy. These terms are capitalized wherever they appear in the policy.

ACCIDENT means accidental bodily Injury or Injuries causing Loss under this policy. Such Injuries must be caused directly and independent of disease or bodily infirmity or any other cause.

BENEFIT PERIOD means a Benefit Period as defined by Medicare.

COMPANY OFFICER means the President or Secretary.

EFFECTIVE DATE means the date your policy coverage begins at 12:01 A.M. where you live. Your policy Effective Date is listed on the policy schedule page.

HOSPITAL means Hospital as defined by Medicare.

INPATIENT HOSPITAL DEDUCTIBLE means the initial amount of Hospital expenses you incur in a Medicare Benefit Period as a resident bed patient under Medicare Part A. Medicare establishes the amount of the Inpatient Hospital Deductible. Medicare does not pay this amount.

INJURY or INJURIES means bodily Injury caused by an Accident and resulting directly and independently of all other causes.

LIFETIME INPATIENT RESERVE DAYS means additional days that Medicare will pay for when you are confined to a Hospital for more than 90 days in a Benefit Period.
.

LOSS means the incurring of Medicare Eligible Expenses while this policy is in force.

MATERIAL INFORMATION means a condition or combination of conditions you were requested to disclose on the application were not disclosed and which, if disclosed, would have required a different premium or caused us to deny issuing your policy.

MEDICALLY NECESSARY means that the service or supply is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and must:

1. Be prescribed by a Physician;
2. Be consistent with the diagnosis and treatment of such Injury or Sickness;
3. Be in accordance with the generally accepted standards of medical practice; and
4. Not be solely for the convenience of the Insured or the Physician.

MEDICAID means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as amended.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965 as then constituted or later amended.

MEDICARE COINSURANCE means the portion of charges covered but not reimbursed by Medicare, excluding the Medicare deductibles, for which you are responsible.

MEDICARE ELIGIBLE EXPENSES means health care expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

MEDICARE PART B DEDUCTIBLE means the amount you must pay each calendar year before benefits will be paid under Medicare Part B. Medicare establishes the amount of the Part B Deductible. Medicare does not pay this amount. A calendar year begins on January 1, and ends on December 31.

PHYSICIAN means a Physician as defined by Medicare.

PREMIUM DUE DATE means the month and day your policy's premium payment is due. The frequency of the Premium Due Date can vary depending on whether your premiums are paid on a monthly, quarterly, semiannual, or annual basis.

RESPITE CARE means treatment that meets Medicare's definition of respite care.

SICKNESS means illness or disease which first manifests itself after your policy's Effective Date and while your policy is in force.

SKILLED NURSING FACILITY means a Skilled Nursing Facility as defined by Medicare.

WRITTEN NOTIFICATION means written notice that you are currently receiving medical assistance or that your medical assistance received has terminated. This notification should include: Insured's name, policy number, copy of the document which indicates the date you became eligible for medical assistance or a copy of the document which indicates the date medical assistance terminated.

Notice must be given by or on behalf of the Insured or the beneficiary to the Home Office, Attn: Policyholders Service Department, or to any authorized agent of the company.

BENEFIT PROVISIONS

BASIC ("CORE") BENEFITS

TO SUPPLEMENT BENEFITS UNDER PART A OF MEDICARE:

1. We will pay all Part A Medicare Coinsurance for inpatient Hospital confinement to the extent not covered by Medicare from the 61st day through 90th day in any Medicare Benefit Period.

2. We will pay all Part A Medicare Coinsurance incurred for each Lifetime Inpatient Reserve Day to the extent not covered by Medicare. Lifetime Inpatient Reserve Days are nonrenewable and limited to 60 days during your lifetime.

3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the Lifetime Inpatient Reserve Days, we will pay one hundred percent of the Part A Medicare Eligible Expenses for inpatient Hospital confinement. Benefits are payable at the same rate Medicare would have paid had Medicare Part A Hospital days not been exhausted. Medicare exhaustion benefits are limited to a lifetime maximum of 365 days of inpatient Hospital confinement.

4. We will pay under Medicare Parts A and B the reasonable cost of the first three 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

5. We will pay the co-payment/coinsurance amount for all Part A Medicare Eligible Expenses for hospice care and Respite Care.

TO SUPPLEMENT BENEFITS UNDER PART B OF MEDICARE:

1. We will pay all of the Medicare Coinsurance amount, or in the case of hospital outpatient mdepartment services, paid under a prospective payment system, the copayment amount of Medicare Part B eligible Expenses regardless of Hospital confinement, subject to the Medicare Part B Deductible.

CHANGES IN MEDICARE COINSURANCE AND DEDUCTIBLES

Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

EXCLUSIONS

We will not pay for:

1. Loss incurred while your policy is not in force, except as provided in the Extension of Benefits section of your policy;
2. Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this policy is not in force;
3. That portion of any Loss incurred which is paid for by Medicare;
4. Services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take-home drugs and eye refractions;
5. Services for which a charge is not normally made in the absence of insurance;
6. Loss that is payable under any other Medicare supplement insurance policy or certificate; or
7. Loss that is payable under any other insurance which paid benefits for the same Loss on an expense incurred basis.

RECEIPT OF MEDICAL ASSISTANCE

Benefits and premium(s) under this policy shall be suspended upon your request for any period, (that may be provided by law), in which you have applied for and qualified for the receipt of medical assistance under Title XIX of the Social Security Act (Medicaid), but **only** if you notify us within ninety (90) days after the date you became entitled to such assistance.

If such suspension occurs and if you lose entitlement to such medical assistance, this policy shall be automatically reinstituted, effective as of the date of termination of such entitlement, if you provide Written Notification of loss of such entitlement within ninety (90) days after the date of such loss of entitlement and pay the premium attributable to this period, effective as of the date of termination of such entitlement.

Benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at your request if you are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if you lose coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if you provide notice of loss of coverage within 90 days after the date of loss.

If such reinstitution occurs:

1. Your policy shall not provide for any waiting period with respect to treatment of Pre-Existing Conditions;

2. Your benefits provided under the reinstitution will be substantially the same as the benefits in effect before the date of such suspension; and

3. Your premium classification terms provided under the reinstitution will be at least as favorable to you as the premium terms that would have applied had this policy not been suspended.

POLICY TERMINATION

Your policy will terminate on the earliest of:

1. The date we receive your written request to cancel your policy (in which case the grace period will not apply);
2. The date your policy is replaced by another Medicare supplement or Medicare Select policy or by a Part C Medicare Advantage plan (in which case the grace period will not apply);
3. The Premium Due Date, if sufficient premium has not been paid before the end of the grace period; or
4. The date and time of your death.

In the event of cancellation or death, we will promptly return the unearned portion of any premium paid.

POLICY PROVISIONS

ENTIRE CONTRACT; CHANGES: This policy, the application and any attached papers constitute the entire contract. No one has the authority to change this policy or to waive any of its provisions unless the change is approved in writing by a Company Officer. The approval must be written on or attached to this policy.

TIME LIMIT ON CERTAIN DEFENSES:

1. **Misstatement in your application:** We issued your policy based on information we were provided on your application. Any incorrect or omitted Material Information in your application may cause your policy to be rescinded (voided) back to the Effective Date of your policy or a claim to be denied.

2. **Time limit on certain defenses:**

   a. We may rescind (void) this policy or deny a claim for Loss incurred within 2 years from your policy Effective Date because of misstatement in your application.

   b. We may rescind (void) your policy or deny a claim for Loss incurred any time after 2 years from your policy's Effective Date only for fraudulent misstatement in your application.

GRACE PERIOD: A grace period of 31 days from your Premium Due Date will be allowed for late payment of premium. During such grace period, this policy will not lapse as long as you pay your full premium before the end of the grace period.

REINSTATEMENT: If any premium is not paid within the time your payment is due, a subsequent acceptance of premium by us or by any agent authorized by us to accept such premium, without requiring an application for reinstatement, shall reinstate your policy. However, if we or our agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, your policy will be reinstated only upon approval of the application by us or, lacking such approval, upon the 45th day following the date of the conditional receipt, unless we have previously notified you in writing of our disapproval of your application. If the application for reinstatement is disapproved, any premium received will be returned to you. If the application for reinstatement is approved, the reinstated policy will cover only Loss resulting from Injury or Sickness sustained after the Effective Date of reinstatement. In all other respects, you and the company shall have the same rights under this policy as were in effect before it lapsed, subject to the provisions of any rider which may be attached in connection with the reinstatement.

NOTICE OF CLAIM: Written notice of claim must be given to the company within twenty days after the beginning of any Loss covered by this policy. If notice cannot be given within that period, it must be given as soon as is reasonably possible. The notice will be considered sufficient if it identifies you and is given to the company at its Home Office or to any authorized agent of the company.

CLAIM FORMS: The company, after receiving notice of claim, will furnish to the claimant forms for filing proof of Loss. If forms are not furnished within 15 days after the giving of such notice, the claimant will be considered to have met the requirements of this policy for proof of Loss if the company is furnished proof of Loss as stated below.

TIME OF PAYMENT OF CLAIMS: Benefits payable under this policy will be paid promptly after the company receives suitable written proof of Loss.

PROOF OF LOSS: Written proof of Loss must be sent to the company at its Home Office within 90 days after the date of Loss. Failure to furnish proof within 90 days shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

PAYMENT OF CLAIMS: All benefits are payable to you unless we receive proof of an assignment of benefits to pay your health care provider. At your death, any accrued benefits unpaid, and which are not assigned, or unearned premium will be paid to your estate.

REFUND OF UNEARNED PREMIUM UPON DEATH OF INSURED: The company shall refund any premium paid for the period beyond the end of the policy month in which the death occurred. Unearned premium shall be paid in a lump sum to your estate no later than 30 days after receipt of proof of death is received by the company.

PHYSICAL EXAMINATIONS AND AUTOPSY: We, at our expense, shall have the right and opportunity to have a Physician examine you when and as often as we may reasonably require while a claim is pending under your policy, and to request an autopsy in case of death where it is not prohibited by law.

LEGAL ACTION: No action at law or in equity can be brought to recover on this policy until 60 days after written proof of Loss has been given to the company. No action can be brought after 3 years from the date written proof of Loss is required.

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its Effective Date, is in conflict with the statutes of the state in which you reside on such date is automatically changed to meet the minimum requirements of such statutes.

ASSIGNMENT: No assignment of interest under this policy will be binding upon the company unless notice of the assignment is received at the Home Office of the company. The company does not assume any responsibility for the assignment's validity.

MISSTATEMENT OF AGE OR GENDER: If your age or gender has been misstated in your application for this policy, your premium will be adjusted based on your correct age or gender upon reasonable notice to you. If based on your true age this policy would not have been issued, we will be liable only for the refund of premiums paid for this policy.

UNPAID PREMIUMS: When benefits are paid for a claim under this policy, any premium due and unpaid may be deducted, at our option, from the benefits payable.

EXTENSION OF BENEFITS: Termination of your policy shall be without prejudice to any continuous Loss which commenced while your policy was in force, but the extension of benefits beyond the period that your policy was in force is: (a) subject to your continuous total disability; (b) limited to the duration of the Medicare Benefit Period or, if none is applicable, payment of the maximum benefits; and (c) limited to the covered Injury or Sickness causing the continuous loss beginning while your policy was in force. Receipt of Medicare Part D benefits will not be considered in determining a continuous Loss.

TERM OF COVERAGE: Your coverage starts on the Effective Date at 12:01 A.M. where you live. It ends at 12:01 A.M. where you live on the termination date as described in the Policy Termination section.

IN WITNESS WHEREOF, American Continental Insurance Company has caused this policy to be signed and attested by its authorized Company Officers.

President

Secretary

AMERICAN CONTINENTAL INSURANCE COMPANY

HOME OFFICE
101 Continental Place
Brentwood, Tennessee 37027
Telephone: 1-800-264-4000

MEDICARE SUPPLEMENT POLICY

THIS IS A PLAN "A"

If you need information or have any questions regarding your policy, please contact:

Policyholder Services
P. O. Box 2368
Brentwood, Tennessee 37024-1188
(800) 264-4000