



American National Life Insurance Company of Texas
P.O. Box 1820, Galveston, TX 77553-1820, 800.899.6520

Outline of Medicare Supplement Coverage — Cover Page: 1 of 2
Benefit Plans A, B, C, D, E, F and G

These charts show the benefits included in each of the standard Medicare Supplement plans. Every company must make available Plan A. Some plans may not be available in your state. See Outlines of Coverage sections for details about ALL plans.

BASIC BENEFITS (For Plans A-J) —

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.

Blood: First three pints of blood each year.

A ✓	B ✓	C ✓	D ✓	E ✓	F ✓	F*	G ✓	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance		Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible						Part B Deductible
					Part B Excess (100%)		Part B Excess (80%)			Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	At-Home Recovery
				Preventive Care NOT Covered By Medicare							Preventive Care NOT Covered By Medicare
Policy Form ANL-SS05 Plan A	Policy Form ANL-SS05 Plan B	Policy Form ANL-SS05 Plan C	Policy Form ANL-SS05 Plan D	Policy Form ANL-SS05 Plan E	Policy Forms ANL-SS05 Plan F		Policy Form ANL-SS05 Plan G				

*Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year \$2000 deductible. Benefits from high deductible Plans F and J 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.

THIS PAGE IS LEFT INTENTIONALLY BLANK.

American National Life Insurance Company of Texas
P.O. Box 1820, Galveston, TX 77553-1820, 800.899.6520

Outline of Medicare Supplement Coverage —
Cover Page: 2 of 2

BASIC BENEFITS (For Plans K and L) —
Basic Benefits for Plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

K**	L**	
100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End	
50% Hospice cost-sharing	75% Hospice cost-sharing	
50% of Medicare-eligible expenses for the first three pints of blood	75% of Medicare-eligible expenses for the first three pints of blood	
50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	
50% Part A Deductible	75% Part A Deductible	
\$4,620 Out of Pocket Annual Limit***	\$2,310 Out of Pocket Annual Limit***	

**Plans K and L provide for different cost-sharing for items and services than Plans A-J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

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

See Outlines of Coverage for details and exceptions.

GEORGIA PREMIUMS FOR ZIP CODES (306, 307, 317-319)

2009		PLAN A RATES*												2009		
Issue Age	FEMALE RATES								MALE RATES							
	Non Tobacco User				Tobacco User				Non Tobacco User				Tobacco User			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
Under 65 Disability	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	\$1,152.89	\$593.74	\$305.52	\$100.30	\$1,280.99	\$659.71	\$339.46	\$111.45	\$1,297.75	\$668.34	\$343.90	\$112.90	\$1,441.94	\$742.60	\$382.11	\$125.45
66	1,152.89	593.74	305.52	100.30	1,280.99	659.71	339.46	111.45	1,297.75	668.34	343.90	112.90	1,441.94	742.60	382.11	125.45
67	1,199.52	617.75	317.87	104.36	1,332.80	686.39	353.19	115.95	1,350.33	695.42	357.84	117.48	1,500.37	772.69	397.60	130.53
68	1,254.09	645.86	332.33	109.11	1,393.43	717.62	369.26	121.23	1,411.85	727.10	374.14	122.83	1,568.72	807.89	415.71	136.48
69	1,302.71	670.90	345.22	113.34	1,447.45	745.44	383.57	125.93	1,466.42	755.21	388.60	127.58	1,629.35	839.12	431.78	141.75
70	1,320.56	680.09	349.95	114.89	1,467.29	755.65	388.83	127.65	1,499.16	772.07	397.28	130.43	1,665.73	857.85	441.42	144.92
71	1,355.29	697.97	359.15	117.91	1,505.88	775.53	399.06	131.01	1,541.82	794.04	408.58	134.14	1,713.13	882.26	453.98	149.04
72	1,379.11	710.24	365.46	119.98	1,532.34	789.16	406.07	133.31	1,571.58	809.36	416.47	136.73	1,746.20	899.29	462.74	151.92
73	1,392.99	717.39	369.14	121.19	1,547.77	797.10	410.16	134.66	1,584.48	816.01	419.89	137.85	1,760.53	906.67	466.54	153.17
74	1,405.89	724.03	372.56	122.31	1,562.10	804.48	413.96	135.90	1,596.38	822.14	423.04	138.89	1,773.76	913.49	470.05	154.32
75	1,419.78	731.19	376.24	123.52	1,577.53	812.43	418.05	137.25	1,608.29	828.27	426.20	139.92	1,786.99	920.30	473.55	155.47
76	1,432.68	737.83	379.66	124.64	1,591.87	819.81	421.85	138.49	1,620.20	834.40	429.35	140.96	1,800.22	927.11	477.06	156.62
77	1,446.57	744.98	383.34	125.85	1,607.30	827.76	425.93	139.84	1,633.10	841.05	432.77	142.08	1,814.55	934.49	480.86	157.87
78	1,447.56	745.49	383.60	125.94	1,608.40	828.33	426.23	139.93	1,634.09	841.56	433.03	142.17	1,815.65	935.06	481.15	157.96
79	1,449.55	746.52	384.13	126.11	1,610.61	829.46	426.81	140.12	1,636.07	842.58	433.56	142.34	1,817.86	936.20	481.73	158.15
80	1,450.54	747.03	384.39	126.20	1,611.71	830.03	427.10	140.22	1,638.05	843.60	434.08	142.51	1,820.06	937.33	482.32	158.35
81	1,452.52	748.05	384.92	126.37	1,613.91	831.16	427.69	140.41	1,640.04	844.62	434.61	142.68	1,822.27	938.47	482.90	158.54
82	1,453.52	748.56	385.18	126.46	1,615.02	831.74	427.98	140.51	1,641.03	845.13	434.87	142.77	1,823.37	939.04	483.19	158.63
83	1,454.51	749.07	385.45	126.54	1,616.12	832.30	428.27	140.60	1,642.02	845.64	435.14	142.86	1,824.47	939.60	483.48	158.73
84	1,456.49	750.09	385.97	126.71	1,618.32	833.43	428.85	140.79	1,644.01	846.67	435.66	143.03	1,826.68	940.74	484.07	158.92
85+	1,457.49	750.61	386.23	126.80	1,619.43	834.01	429.15	140.89	1,645.00	847.18	435.93	143.12	1,827.78	941.31	484.36	159.02

Page 4

2009		PLAN B RATES*												2009		
Under 65 Disability	FEMALE RATES								MALE RATES							
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
Under 65 Disability	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	\$1,477.48	\$760.90	\$391.53	\$128.54	\$1,641.64	\$845.44	\$435.03	\$142.82	\$1,651.60	\$850.57	\$437.67	\$143.69	\$1,835.11	\$945.08	\$486.30	\$159.65
66	1,477.48	760.90	391.53	128.54	1,641.64	845.44	435.03	142.82	1,651.60	850.57	437.67	143.69	1,835.11	945.08	486.30	159.65
67	1,537.24	791.68	407.37	133.74	1,708.04	879.64	452.63	148.60	1,718.58	885.07	455.42	149.52	1,909.53	983.41	506.03	166.13
68	1,607.30	827.76	425.93	139.84	1,785.89	919.73	473.26	155.37	1,795.85	924.86	475.90	156.24	1,995.39	1,027.63	528.78	173.60
69	1,670.15	860.13	442.59	145.30	1,855.72	955.70	491.77	161.45	1,865.91	960.94	494.47	162.33	2,073.23	1,067.71	549.41	180.37
70	1,733.00	892.50	459.25	150.77	1,925.55	991.66	510.27	167.52	1,946.28	1,002.33	515.76	169.33	2,162.53	1,113.70	573.07	188.14
71	1,789.67	921.68	474.26	155.70	1,988.52	1,024.09	526.96	173.00	2,011.19	1,035.76	532.97	174.97	2,234.65	1,150.84	592.18	194.41
72	1,833.97	944.49	486.00	159.56	2,037.74	1,049.44	540.00	177.28	2,062.70	1,062.29	546.62	179.45	2,291.89	1,180.32	607.35	199.39
73	1,864.88	960.41	494.19	162.24	2,072.09	1,067.13	549.10	180.27	2,089.49	1,076.09	553.71	181.79	2,321.65	1,195.65	615.24	201.98
74	1,896.82	976.86	502.66	165.02	2,107.58	1,085.40	558.51	183.36	2,117.30	1,090.41	561.08	184.21	2,352.56	1,211.57	623.43	204.67
75	1,928.76	993.31	511.12	167.80	2,143.07	1,103.68	567.91	186.45	2,145.12	1,104.74	568.46	186.63	2,383.47	1,227.49	631.62	207.36
76	1,960.70	1,009.76	519.59	170.58	2,178.55	1,121.95	577.32	189.53	2,171.92	1,118.54	575.56	188.96	2,413.24	1,242.82	639.51	209.95
77	1,992.64	1,026.21	528.05	173.36	2,214.04	1,140.23	586.72	192.62	2,199.74	1,132.87	582.93	191.38	2,444.15	1,258.74	647.70	212.64
78	2,015.31	1,037.88	534.06	175.33	2,239.23	1,153.20	593.40	194.81	2,212.10	1,139.23	586.21	192.45	2,457.89	1,265.81	651.34	213.84
79	2,036.94	1,049.02	539.79	177.21	2,263.27	1,165.58	599.77	196.90	2,223.43	1,145.07	589.21	193.44	2,470.48	1,272.30	654.68	214.93
80	2,059.61	1,060.70	545.80	179.19	2,288.46	1,178.56	606.44	199.10	2,235.80	1,151.44	592.49	194.51	2,484.22	1,279.37	658.32	216.13
81	2,081.25	1,071.84	551.53	181.07	2,312.50	1,190.94	612.81	201.19	2,248.16	1,157.80	595.76	195.59	2,497.95	1,286.44	661.96	217.32
82	2,103.91	1,083.51	557.54	183.04	2,337.68	1,203.91	619.49	203.38	2,260.52	1,164.17	599.04	196.67	2,511.69	1,293.52	665.60	218.52
83	2,105.97	1,084.57	558.08	183.22	2,339.97	1,205.08	620.09	203.58	2,262.58	1,165.23	599.58	196.84	2,513.98	1,294.70	666.20	218.72
84	2,107.01	1,085.11	558.36	183.31	2,341.12	1,205.68	620.40	203.68	2,264.64	1,166.29	600.13	197.02	2,516.27	1,295.88	666.81	218.92
85+	2,109.07	1,086.17	558.90	183.49	2,343.41	1,206.86	621.00	203.88	2,266.70	1,167.35	600.68	197.20	2,518.56	1,297.06	667.42	219.11

*Add a one time \$20.00 application fee to the modal premium for the plan selected.

GEORGIA PREMIUMS FOR ZIP CODES (306, 307, 317-319)

2009		PLAN C RATES*												2009		
Issue Age	FEMALE RATES								MALE RATES							
	Non Tobacco User				Tobacco User				Non Tobacco User				Tobacco User			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
Under 65 Disability	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	\$1,676.33	\$ 863.31	\$444.23	\$145.84	\$1,862.59	\$ 959.23	\$493.59	\$162.05	\$1,873.13	\$ 964.66	\$496.38	\$162.96	\$2,081.25	\$1,071.84	\$551.53	\$181.07
66	1,676.33	863.31	444.23	145.84	1,862.59	959.23	493.59	162.05	1,873.13	964.66	496.38	162.96	2,081.25	1,071.84	551.53	181.07
67	1,744.34	898.34	462.25	151.76	1,938.15	998.15	513.61	168.62	1,949.36	1,003.92	516.58	169.59	2,165.96	1,115.47	573.98	188.44
68	1,822.64	938.66	483.00	158.57	2,025.15	1,042.95	536.66	176.19	2,036.94	1,049.02	539.79	177.21	2,263.27	1,165.58	599.77	196.90
69	1,893.73	975.27	501.84	164.75	2,104.14	1,083.63	557.60	183.06	2,116.28	1,089.88	560.81	184.12	2,351.42	1,210.98	623.13	204.57
70	1,965.85	1,012.41	520.95	171.03	2,184.28	1,124.90	578.83	190.03	2,205.92	1,136.05	584.57	191.92	2,451.02	1,262.28	649.52	213.24
71	2,030.76	1,045.84	538.15	176.68	2,256.40	1,162.05	597.95	196.31	2,281.13	1,174.78	604.50	198.46	2,534.59	1,305.31	671.67	220.51
72	2,079.19	1,070.78	550.99	180.89	2,310.21	1,189.76	612.21	200.99	2,338.83	1,204.50	619.79	203.48	2,598.70	1,338.33	688.66	226.09
73	2,115.24	1,089.35	560.54	184.03	2,350.27	1,210.39	622.82	204.47	2,369.74	1,220.42	627.98	206.17	2,633.04	1,356.02	697.76	229.07
74	2,151.31	1,107.92	570.10	187.16	2,390.34	1,231.03	633.44	207.96	2,400.64	1,236.33	636.17	208.86	2,667.38	1,373.70	706.86	232.06
75	2,187.37	1,126.50	579.65	190.30	2,430.41	1,251.66	644.06	211.45	2,432.58	1,252.78	644.63	211.63	2,702.87	1,391.98	716.26	235.15
76	2,223.43	1,145.07	589.21	193.44	2,470.48	1,272.30	654.68	214.93	2,463.50	1,268.70	652.83	214.32	2,737.22	1,409.67	725.36	238.14
77	2,259.50	1,163.64	598.77	196.58	2,510.55	1,292.93	665.30	218.42	2,494.40	1,284.62	661.02	217.01	2,771.56	1,427.35	734.46	241.13
78	2,285.25	1,176.90	605.59	198.82	2,539.17	1,307.67	672.88	220.91	2,507.80	1,291.52	664.57	218.18	2,786.44	1,435.02	738.41	242.42
79	2,309.98	1,189.64	612.14	200.97	2,566.64	1,321.82	680.16	223.30	2,522.22	1,298.94	668.39	219.43	2,802.47	1,443.27	742.65	243.81
80	2,335.73	1,202.90	618.97	203.21	2,595.26	1,336.56	687.74	225.79	2,535.62	1,305.84	671.94	220.60	2,817.35	1,450.94	746.60	245.11
81	2,360.47	1,215.64	625.52	205.36	2,622.74	1,350.71	695.03	228.18	2,550.04	1,313.27	675.76	221.85	2,833.38	1,459.19	750.85	246.50
82	2,385.19	1,228.37	632.08	207.51	2,650.21	1,364.86	702.31	230.57	2,563.43	1,320.17	679.31	223.02	2,848.26	1,466.85	754.79	247.80
83	2,387.25	1,229.43	632.62	207.69	2,652.50	1,366.04	702.91	230.77	2,565.50	1,321.23	679.86	223.20	2,850.55	1,468.03	755.40	248.00
84	2,390.35	1,231.03	633.44	207.96	2,655.94	1,367.81	703.82	231.07	2,568.59	1,322.82	680.68	223.47	2,853.99	1,469.80	756.31	248.30
85+	2,392.41	1,232.09	633.99	208.14	2,658.23	1,368.99	704.43	231.27	2,570.65	1,323.88	681.22	223.65	2,856.28	1,470.98	756.91	248.50

2009		PLAN D RATES*												2009		
Under 65 Disability	PLAN D RATES*															
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
Under 65 Disability	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	\$1,361.24	\$701.04	\$360.73	\$118.43	\$1,512.49	\$ 778.93	\$400.81	\$131.59	\$1,483.28	\$ 763.89	\$393.07	\$129.05	\$1,648.09	\$ 848.77	\$436.74	\$143.38
66	1,361.24	701.04	360.73	118.43	1,512.49	778.93	400.81	131.59	1,483.28	763.89	393.07	129.05	1,648.09	848.77	436.74	143.38
67	1,415.81	729.14	375.19	123.18	1,573.12	810.16	416.88	136.86	1,543.80	795.06	409.11	134.31	1,715.33	883.39	454.56	149.23
68	1,476.33	760.31	391.23	128.44	1,640.37	844.79	434.70	142.71	1,585.48	816.52	420.15	137.94	1,761.64	907.24	466.83	153.26
69	1,508.09	776.67	399.64	131.20	1,675.65	862.96	444.05	145.78	1,623.18	835.94	430.14	141.22	1,803.53	928.82	477.94	156.91
70	1,525.94	785.86	404.37	132.76	1,695.49	873.18	449.30	147.51	1,649.96	849.73	437.24	143.55	1,833.29	944.14	485.82	159.50
71	1,538.84	792.50	407.79	133.88	1,709.82	880.56	453.10	148.75	1,665.84	857.91	441.45	144.93	1,850.93	953.23	490.50	161.03
72	1,552.73	799.66	411.47	135.09	1,725.26	888.51	457.19	150.10	1,683.69	867.10	446.18	146.48	1,870.77	963.45	495.75	162.76
73	1,570.59	808.85	416.21	136.64	1,745.10	898.73	462.45	151.82	1,710.49	880.90	453.28	148.81	1,900.54	978.78	503.64	165.35
74	1,602.34	825.21	424.62	139.40	1,780.38	916.90	471.80	154.89	1,737.27	894.69	460.38	151.14	1,930.30	994.10	511.53	167.94
75	1,634.09	841.56	433.03	142.17	1,815.65	935.06	481.15	157.96	1,764.06	908.49	467.48	153.47	1,960.07	1,009.44	519.42	170.53
76	1,666.83	858.42	441.71	145.01	1,852.03	953.80	490.79	161.13	1,790.85	922.29	474.58	155.80	1,989.83	1,024.76	527.30	173.12
77	1,698.58	874.77	450.12	147.78	1,887.31	971.96	500.14	164.20	1,817.64	936.08	481.67	158.13	2,019.60	1,040.09	535.19	175.71
78	1,724.37	888.05	456.96	150.02	1,915.97	986.72	507.73	166.69	1,840.46	947.84	487.72	160.12	2,044.95	1,053.15	541.91	177.91
79	1,750.17	901.34	463.80	152.26	1,944.63	1,001.48	515.33	169.18	1,862.28	959.07	493.50	162.02	2,069.20	1,065.64	548.34	180.02
80	1,775.97	914.62	470.63	154.51	1,973.30	1,016.25	522.92	171.68	1,884.11	970.32	499.29	163.92	2,093.46	1,078.13	554.77	182.13
81	1,801.76	927.91	477.47	156.75	2,001.96	1,031.01	530.52	174.17	1,905.94	981.56	505.07	165.82	2,117.71	1,090.62	561.19	184.24
82	1,827.56	941.19	484.30	159.00	2,030.62	1,045.77	538.11	176.66	1,927.76	992.80	510.86	167.72	2,141.96	1,103.11	567.62	186.35
83	1,833.52	944.26	485.88	159.52	2,037.24	1,049.18	539.87	177.24	1,933.72	995.87	512.44	168.23	2,148.58	1,106.52	569.37	186.93
84	1,838.48	946.82	487.20	159.95	2,042.75	1,052.02	541.33	177.72	1,939.67	998.93	514.01	168.75	2,155.19	1,109.92	571.13	187.50
85+	1,844.42	949.88	488.77	160.46	2,049.36	1,055.42	543.08	178.29	1,945.63	1,002.00	515.59	169.27	2,161.81	1,113.33	572.88	188.08

*Add a one time \$20.00 application fee to the modal premium for the plan selected.

GEORGIA PREMIUMS FOR ZIP CODES (306, 307, 317-319)

2009		PLAN E RATES*												2009		
Issue Age	FEMALE RATES								MALE RATES							
	Non Tobacco User				Tobacco User				Non Tobacco User				Tobacco User			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
Under 65 Disability	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	\$1,337.36	\$688.74	\$354.40	\$116.35	\$1,485.95	\$765.26	\$393.78	\$129.28	\$1,492.94	\$768.86	\$395.63	\$129.89	\$1,658.82	\$ 854.29	\$439.59	\$144.32
66	1,337.36	688.74	354.40	116.35	1,485.95	765.26	393.78	129.28	1,492.94	768.86	395.63	129.89	1,658.82	854.29	439.59	144.32
67	1,390.93	716.33	368.60	121.01	1,545.48	795.92	409.55	134.46	1,553.72	800.17	411.74	135.17	1,726.36	889.08	457.49	150.19
68	1,419.78	731.19	376.24	123.52	1,577.53	812.43	418.05	137.25	1,589.79	818.74	421.29	138.31	1,766.43	909.71	468.10	153.68
69	1,432.14	737.55	379.52	124.60	1,591.27	819.50	421.69	138.44	1,605.24	826.70	425.39	139.66	1,783.60	918.55	472.65	155.17
70	1,444.51	743.92	382.80	125.67	1,605.01	826.58	425.33	139.64	1,612.45	830.41	427.30	140.28	1,791.61	922.68	474.78	155.87
71	1,457.90	750.82	386.34	126.84	1,619.89	834.24	429.27	140.93	1,622.75	835.72	430.03	141.18	1,803.06	928.58	477.81	156.87
72	1,468.21	756.13	389.08	127.73	1,631.34	840.14	432.31	141.93	1,637.18	843.15	433.85	142.43	1,819.09	936.83	482.06	158.26
73	1,487.78	766.21	394.26	129.44	1,653.09	851.34	438.07	143.82	1,653.66	851.63	438.22	143.87	1,837.40	946.26	486.91	159.85
74	1,508.39	776.82	399.72	131.23	1,675.99	863.13	444.14	145.81	1,674.27	862.25	443.68	145.66	1,860.30	958.05	492.98	161.85
75	1,518.70	782.13	402.46	132.13	1,687.44	869.03	447.17	146.81	1,686.64	868.62	446.96	146.74	1,874.04	965.13	496.62	163.04
76	1,541.36	793.80	408.46	134.10	1,712.62	882.00	453.84	149.00	1,699.00	874.99	450.24	147.81	1,887.78	972.21	500.26	164.24
77	1,567.12	807.07	415.29	136.34	1,741.24	896.74	461.43	151.49	1,720.64	886.13	455.97	149.70	1,911.82	984.59	506.63	166.33
78	1,580.51	813.96	418.84	137.50	1,756.12	904.40	465.37	152.78	1,726.81	889.31	457.60	150.23	1,918.68	988.12	508.45	166.93
79	1,594.94	821.39	422.66	138.76	1,772.15	912.66	469.62	154.18	1,733.00	892.50	459.25	150.77	1,925.55	991.66	510.27	167.52
80	1,609.36	828.82	426.48	140.01	1,788.18	920.91	473.87	155.57	1,739.18	895.68	460.88	151.31	1,932.42	995.20	512.09	168.12
81	1,622.75	835.72	430.03	141.18	1,803.06	928.58	477.81	156.87	1,745.36	898.86	462.52	151.85	1,939.29	998.73	513.91	168.72
82	1,637.18	843.15	433.85	142.43	1,819.09	936.83	482.06	158.26	1,751.54	902.04	464.16	152.38	1,946.16	1,002.27	515.73	169.32
83	1,639.24	844.21	434.40	142.61	1,821.38	938.01	482.67	158.46	1,752.57	902.57	464.43	152.47	1,947.30	1,002.86	516.03	169.42
84	1,640.27	844.74	434.67	142.70	1,822.52	938.60	482.97	158.56	1,754.63	903.63	464.98	152.65	1,949.59	1,004.04	516.64	169.61
85+	1,641.30	845.27	434.94	142.79	1,823.67	939.19	483.27	158.66	1,756.69	904.70	465.52	152.83	1,951.88	1,005.22	517.25	169.81

2009		PLAN F RATES*												2009		
Under 65 Disability	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	\$1,599.36	\$ 823.67	\$423.83	\$139.14	\$1,777.07	\$ 915.19	\$470.92	\$154.61	\$1,787.87	\$ 920.75	\$473.79	\$155.54	\$1,986.52	\$1,023.06	\$526.43	\$172.83
66	1,599.36	823.67	423.83	139.14	1,777.07	915.19	470.92	154.61	1,787.87	920.75	473.79	155.54	1,986.52	1,023.06	526.43	172.83
67	1,664.85	857.40	441.19	144.84	1,849.83	952.66	490.20	160.94	1,860.30	958.05	492.98	161.85	2,067.00	1,064.51	547.76	179.83
68	1,739.26	895.72	460.90	151.32	1,932.51	995.24	512.12	168.13	1,943.64	1,000.97	515.06	169.10	2,159.60	1,112.19	572.29	187.89
69	1,807.71	930.97	479.04	157.27	2,008.57	1,034.41	532.27	174.75	2,020.04	1,040.32	535.31	175.74	2,244.49	1,155.91	594.79	195.27
70	1,877.17	966.74	497.45	163.31	2,085.74	1,074.16	552.72	181.46	2,106.36	1,084.78	558.19	183.25	2,340.40	1,205.31	620.21	203.61
71	1,937.69	997.91	513.49	168.58	2,152.99	1,108.79	570.54	187.31	2,177.79	1,121.56	577.11	189.47	2,419.77	1,246.18	641.24	210.52
72	1,985.31	1,022.43	526.11	172.72	2,205.90	1,136.04	584.56	191.91	2,233.35	1,150.18	591.84	194.30	2,481.50	1,277.97	657.60	215.89
73	2,020.04	1,040.32	535.31	175.74	2,244.49	1,155.91	594.79	195.27	2,263.11	1,165.50	599.72	196.89	2,514.57	1,295.00	666.36	218.77
74	2,053.77	1,057.69	544.25	178.68	2,281.97	1,175.21	604.72	198.53	2,292.89	1,180.84	607.62	199.48	2,547.65	1,312.04	675.13	221.65
75	2,088.50	1,075.58	553.45	181.70	2,320.55	1,195.08	614.95	201.89	2,321.66	1,195.65	615.24	201.98	2,579.62	1,328.50	683.60	224.43
76	2,123.23	1,093.46	562.66	184.72	2,359.14	1,214.96	625.17	205.25	2,351.42	1,210.98	623.13	204.57	2,612.69	1,345.54	692.36	227.30
77	2,157.95	1,111.34	571.86	187.74	2,397.72	1,234.83	635.40	208.60	2,381.18	1,226.31	631.01	207.16	2,645.76	1,362.57	701.13	230.18
78	2,181.76	1,123.61	578.17	189.81	2,424.18	1,248.45	642.41	210.90	2,394.08	1,232.95	634.43	208.28	2,660.09	1,369.95	704.92	231.43
79	2,205.58	1,135.87	584.48	191.89	2,450.64	1,262.08	649.42	213.21	2,407.97	1,240.10	638.11	209.49	2,675.52	1,377.89	709.01	232.77
80	2,229.38	1,148.13	590.79	193.96	2,477.09	1,275.70	656.43	215.51	2,420.87	1,246.75	641.53	210.62	2,689.86	1,385.28	712.81	234.02
81	2,253.20	1,160.40	597.10	196.03	2,503.55	1,289.33	663.44	217.81	2,433.77	1,253.39	644.95	211.74	2,704.19	1,392.66	716.61	235.26
82	2,278.00	1,173.17	603.67	198.19	2,531.11	1,303.52	670.74	220.21	2,447.66	1,260.54	648.63	212.95	2,719.62	1,400.60	720.70	236.61
83	2,279.99	1,174.19	604.20	198.36	2,533.32	1,304.66	671.33	220.40	2,449.65	1,261.57	649.16	213.12	2,721.83	1,401.74	721.28	236.80
84	2,281.97	1,175.21	604.72	198.53	2,535.52	1,305.79	671.91	220.59	2,451.63	1,262.59	649.68	213.29	2,724.03	1,402.88	721.87	236.99
85+	2,283.95	1,176.23	605.25	198.70	2,537.72	1,306.93	672.50	220.78	2,454.61	1,264.12	650.47	213.55	2,727.34	1,404.58	722.75	237.28

*Add a one time \$20.00 application fee to the modal premium for the plan selected.

GEORGIA PREMIUMS FOR ZIP CODES (306, 307, 317-319)

2009		PLAN G RATES*												2009		
Issue Age	FEMALE RATES								MALE RATES							
	Non Tobacco User				Tobacco User				Non Tobacco User				Tobacco User			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
Under 65 Disability	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	\$1,351.32	\$695.93	\$358.10	\$117.56	\$1,501.47	\$ 773.26	\$397.89	\$130.63	\$1,472.36	\$758.27	\$390.18	\$128.10	\$1,635.96	\$ 842.52	\$433.53	\$142.33
66	1,351.32	695.93	358.10	117.56	1,501.47	773.26	397.89	130.63	1,472.36	758.27	390.18	128.10	1,635.96	842.52	433.53	142.33
67	1,405.89	724.03	372.56	122.31	1,562.10	804.48	413.96	135.90	1,532.89	789.44	406.22	133.36	1,703.21	877.15	451.35	148.18
68	1,469.39	756.74	389.39	127.84	1,632.65	840.81	432.65	142.04	1,601.34	824.69	424.36	139.32	1,779.27	916.32	471.51	154.80
69	1,494.19	769.51	395.96	129.99	1,660.21	855.01	439.96	144.44	1,633.10	841.05	432.77	142.08	1,814.55	934.49	480.86	157.87
70	1,506.10	775.64	399.12	131.03	1,673.44	861.82	443.46	145.59	1,646.98	848.19	436.45	143.29	1,829.98	942.44	484.94	159.21
71	1,516.02	780.75	401.75	131.89	1,684.47	867.50	446.38	146.55	1,657.90	853.82	439.34	144.24	1,842.11	948.69	488.16	160.26
72	1,528.92	787.39	405.16	133.02	1,698.80	874.88	450.18	147.80	1,671.79	860.97	443.02	145.45	1,857.54	956.63	492.25	161.61
73	1,558.68	802.72	413.05	135.61	1,731.87	891.91	458.95	150.67	1,697.59	874.26	449.86	147.69	1,886.21	971.40	499.85	164.10
74	1,590.44	819.08	421.47	138.37	1,767.15	910.08	468.29	153.74	1,724.37	888.05	456.96	150.02	1,915.97	986.72	507.73	166.69
75	1,623.18	835.94	430.14	141.22	1,803.53	928.82	477.94	156.91	1,751.17	901.85	464.06	152.35	1,945.74	1,002.06	515.62	169.28
76	1,654.92	852.28	438.55	143.98	1,838.80	946.98	487.28	159.98	1,777.95	915.64	471.16	154.68	1,975.50	1,017.38	523.51	171.87
77	1,686.67	868.64	446.97	146.74	1,874.08	965.15	496.63	163.04	1,804.74	929.44	478.26	157.01	2,005.27	1,032.71	531.40	174.46
78	1,712.47	881.92	453.80	148.98	1,902.74	979.91	504.23	165.54	1,826.57	940.68	484.04	158.91	2,029.52	1,045.20	537.82	176.57
79	1,737.27	894.69	460.38	151.14	1,930.30	994.10	511.53	167.94	1,848.39	951.92	489.82	160.81	2,053.77	1,057.69	544.25	178.68
80	1,763.06	907.98	467.21	153.39	1,958.96	1,008.86	519.12	170.43	1,870.22	963.16	495.61	162.71	2,078.02	1,070.18	550.68	180.79
81	1,788.87	921.27	474.05	155.63	1,987.63	1,023.63	526.72	172.92	1,892.05	974.41	501.39	164.61	2,102.28	1,082.67	557.10	182.90
82	1,814.66	934.55	480.88	157.88	2,016.29	1,038.39	534.32	175.42	1,913.88	985.65	507.18	166.51	2,126.53	1,095.16	563.53	185.01
83	1,819.62	937.10	482.20	158.31	2,021.80	1,041.23	535.78	175.90	1,919.83	988.71	508.75	167.03	2,133.14	1,098.57	565.28	185.58
84	1,825.58	940.17	483.78	158.83	2,028.42	1,044.64	537.53	176.47	1,925.78	991.78	510.33	167.54	2,139.76	1,101.98	567.04	186.16
85+	1,830.54	942.73	485.09	159.26	2,033.93	1,047.47	538.99	176.95	1,931.73	994.84	511.91	168.06	2,146.37	1,105.38	568.79	186.73

*Add a one time \$20.00 application fee to the modal premium for the plan selected.

THIS SPACE LEFT INTENTIONALLY BLANK.

GEORGIA PREMIUMS FOR ZIP CODES (300-305, 308-316, 398, 399)

2009		PLAN A RATES*												2009		
Issue Age	FEMALE RATES								MALE RATES							
	Non Tobacco User				Tobacco User				Non Tobacco User				Tobacco User			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
Under 65 Disability	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	\$1,268.18	\$653.11	\$336.07	\$110.33	\$1,409.09	\$725.68	\$373.41	\$122.59	\$1,427.52	\$735.17	\$378.29	\$124.19	\$1,586.13	\$ 816.86	\$420.32	\$137.99
66	1,268.18	653.11	336.07	110.33	1,409.09	725.68	373.41	122.59	1,427.52	735.17	378.29	124.19	1,586.13	816.86	420.32	137.99
67	1,319.47	679.53	349.66	114.79	1,466.08	755.03	388.51	127.55	1,485.37	764.97	393.62	129.23	1,650.41	849.96	437.36	143.59
68	1,379.49	710.44	365.56	120.02	1,532.77	789.38	406.18	133.35	1,553.03	799.81	411.55	135.11	1,725.59	888.68	457.28	150.13
69	1,432.98	737.98	379.74	124.67	1,592.20	819.98	421.93	138.52	1,613.06	830.73	427.46	140.34	1,792.29	923.03	474.96	155.93
70	1,452.62	748.10	384.94	126.38	1,614.02	831.22	427.72	140.42	1,649.07	849.27	437.00	143.47	1,832.30	943.63	485.56	159.41
71	1,490.82	767.77	395.07	129.70	1,656.47	853.08	438.96	144.11	1,696.00	873.44	449.44	147.55	1,884.44	970.49	499.38	163.95
72	1,517.01	781.26	402.01	131.98	1,685.57	868.07	446.68	146.64	1,728.74	890.30	458.12	150.40	1,920.82	989.22	509.02	167.11
73	1,532.30	789.13	406.06	133.31	1,702.55	876.81	451.18	148.12	1,742.92	897.60	461.87	151.63	1,936.58	997.34	513.19	168.48
74	1,546.48	796.44	409.82	134.54	1,718.31	884.93	455.35	149.49	1,756.03	904.36	465.35	152.77	1,951.14	1,004.84	517.05	169.75
75	1,561.75	804.30	413.86	135.87	1,735.28	893.67	459.85	150.97	1,769.12	911.10	468.82	153.91	1,965.69	1,012.33	520.91	171.02
76	1,575.95	811.61	417.63	137.11	1,751.06	901.80	464.03	152.34	1,782.22	917.84	472.29	155.05	1,980.24	1,019.82	524.76	172.28
77	1,591.23	819.48	421.68	138.44	1,768.03	910.54	468.53	153.82	1,796.41	925.15	476.05	156.29	1,996.01	1,027.95	528.94	173.65
78	1,592.32	820.04	421.96	138.53	1,769.24	911.16	468.85	153.92	1,797.50	925.71	476.34	156.38	1,997.22	1,028.57	529.26	173.76
79	1,594.50	821.17	422.54	138.72	1,771.67	912.41	469.49	154.14	1,799.69	926.84	476.92	156.57	1,999.65	1,029.82	529.91	173.97
80	1,595.59	821.73	422.83	138.82	1,772.88	913.03	469.81	154.24	1,801.86	927.96	477.49	156.76	2,002.07	1,031.07	530.55	174.18
81	1,597.77	822.85	423.41	139.01	1,775.30	914.28	470.45	154.45	1,804.05	929.09	478.07	156.95	2,004.50	1,032.32	531.19	174.39
82	1,598.87	823.42	423.70	139.10	1,776.52	914.91	470.78	154.56	1,805.14	929.65	478.36	157.05	2,005.71	1,032.94	531.51	174.50
83	1,599.96	823.98	423.99	139.20	1,777.73	915.53	471.10	154.66	1,806.23	930.21	478.65	157.14	2,006.92	1,033.56	531.83	174.60
84	1,602.14	825.10	424.57	139.39	1,780.15	916.78	471.74	154.87	1,808.42	931.34	479.23	157.33	2,009.35	1,034.82	532.48	174.81
85+	1,603.23	825.66	424.86	139.48	1,781.37	917.41	472.06	154.98	1,809.50	931.89	479.52	157.43	2,010.56	1,035.44	532.80	174.92

2009		PLAN B RATES*												2009		
Under 65 Disability	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	\$1,625.22	\$ 836.99	\$430.68	\$141.39	\$1,805.80	\$ 929.99	\$478.54	\$157.10	\$1,816.76	\$ 935.63	\$481.44	\$158.06	\$2,018.62	\$1,039.59	\$534.93	\$175.62
66	1,625.22	836.99	430.68	141.39	1,805.80	929.99	478.54	157.10	1,816.76	935.63	481.44	158.06	2,018.62	1,039.59	534.93	175.62
67	1,690.96	870.84	448.10	147.11	1,878.84	967.60	497.89	163.46	1,890.43	973.57	500.96	164.47	2,100.48	1,081.75	556.63	182.74
68	1,768.03	910.54	468.53	153.82	1,964.48	1,011.71	520.59	170.91	1,975.44	1,017.35	523.49	171.86	2,194.93	1,130.39	581.66	190.96
69	1,837.16	946.14	486.85	159.83	2,041.29	1,051.26	540.94	177.59	2,052.50	1,057.04	543.91	178.57	2,280.55	1,174.48	604.35	198.41
70	1,906.30	981.74	505.17	165.85	2,118.11	1,090.83	561.30	184.28	2,140.90	1,102.56	567.34	186.26	2,378.78	1,225.07	630.38	206.95
71	1,968.63	1,013.84	521.69	171.27	2,187.37	1,126.50	579.65	190.30	2,212.31	1,139.34	586.26	192.47	2,458.12	1,265.93	651.40	213.86
72	2,017.36	1,038.94	534.60	175.51	2,241.51	1,154.38	594.00	195.01	2,268.97	1,168.52	601.28	197.40	2,521.08	1,298.36	668.09	219.33
73	2,051.37	1,056.46	543.61	178.47	2,279.30	1,173.84	604.01	198.30	2,298.44	1,183.70	609.09	199.96	2,553.82	1,315.22	676.76	222.18
74	2,086.51	1,074.55	552.93	181.53	2,318.34	1,193.95	614.36	201.70	2,329.04	1,199.46	617.20	202.63	2,587.82	1,332.73	685.77	225.14
75	2,121.64	1,092.64	562.23	184.58	2,357.38	1,214.05	624.71	205.09	2,359.64	1,215.21	625.30	205.29	2,621.82	1,350.24	694.78	228.10
76	2,156.77	1,110.74	571.54	187.64	2,396.41	1,234.15	635.05	208.49	2,389.10	1,230.39	633.11	207.85	2,654.56	1,367.10	703.46	230.95
77	2,191.90	1,128.83	580.85	190.70	2,435.44	1,254.25	645.39	211.88	2,419.71	1,246.15	641.22	210.51	2,688.57	1,384.61	712.47	233.91
78	2,216.84	1,141.67	587.46	192.87	2,463.15	1,268.52	652.73	214.29	2,433.31	1,253.15	644.83	211.70	2,703.68	1,392.40	716.48	235.22
79	2,240.64	1,153.93	593.77	194.94	2,489.60	1,282.14	659.74	216.60	2,445.78	1,259.58	648.13	212.78	2,717.53	1,399.53	720.15	236.43
80	2,265.58	1,166.77	600.38	197.11	2,517.31	1,296.41	667.09	219.01	2,459.38	1,266.58	651.74	213.97	2,732.64	1,407.31	724.15	237.74
81	2,289.38	1,179.03	606.69	199.18	2,543.75	1,310.03	674.09	221.31	2,472.98	1,273.58	655.34	215.15	2,747.75	1,415.09	728.15	239.05
82	2,314.31	1,191.87	613.29	201.34	2,571.45	1,324.30	681.43	223.72	2,486.57	1,280.58	658.94	216.33	2,762.86	1,422.87	732.16	240.37
83	2,316.57	1,193.03	613.89	201.54	2,573.97	1,325.59	682.10	223.94	2,488.84	1,281.75	659.54	216.53	2,765.38	1,424.17	732.83	240.59
84	2,317.71	1,193.62	614.19	201.64	2,575.23	1,326.24	682.44	224.05	2,491.11	1,282.92	660.14	216.73	2,767.90	1,425.47	733.49	240.81
85+	2,319.98	1,194.79	614.79	201.84	2,577.75	1,327.54	683.10	224.26	2,493.38	1,284.09	660.75	216.92	2,770.42	1,426.77	734.16	241.03

*Add a one time \$20.00 application fee to the modal premium for the plan selected.

GEORGIA PREMIUMS FOR ZIP CODES (300-305, 308-316, 398, 399)

2009		PLAN C RATES*												2009		
Issue Age	FEMALE RATES								MALE RATES							
	Non Tobacco User				Tobacco User				Non Tobacco User				Tobacco User			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
Under 65 Disability	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	\$1,843.97	\$ 949.64	\$488.65	\$160.43	\$2,048.85	\$1,055.16	\$542.95	\$178.25	\$2,060.44	\$1,061.13	\$546.02	\$179.26	\$2,289.38	\$1,179.03	\$606.69	\$199.18
66	1,843.97	949.64	488.65	160.43	2,048.85	1,055.16	542.95	178.25	2,060.44	1,061.13	546.02	179.26	2,289.38	1,179.03	606.69	199.18
67	1,918.77	988.17	508.47	166.93	2,131.97	1,097.96	564.97	185.48	2,144.30	1,104.31	568.24	186.55	2,382.56	1,227.02	631.38	207.28
68	2,004.90	1,032.52	531.30	174.43	2,227.67	1,147.25	590.33	193.81	2,240.64	1,153.93	593.77	194.94	2,489.60	1,282.14	659.74	216.60
69	2,083.10	1,072.80	552.02	181.23	2,314.55	1,191.99	613.36	201.37	2,327.90	1,198.87	616.89	202.53	2,586.56	1,332.08	685.44	225.03
70	2,162.44	1,113.66	573.05	188.13	2,402.71	1,237.40	636.72	209.04	2,426.51	1,249.65	643.03	211.11	2,696.12	1,388.50	714.47	234.56
71	2,233.84	1,150.43	591.97	194.34	2,482.04	1,278.25	657.74	215.94	2,509.25	1,292.26	664.95	218.30	2,788.05	1,435.85	738.83	242.56
72	2,287.11	1,177.86	606.08	198.98	2,541.23	1,308.73	673.43	221.09	2,572.71	1,324.95	681.77	223.83	2,858.57	1,472.16	757.52	248.70
73	2,326.77	1,198.29	616.59	202.43	2,585.30	1,331.43	685.10	224.92	2,606.71	1,342.46	690.78	226.78	2,896.34	1,491.62	767.53	251.98
74	2,366.43	1,218.71	627.10	205.88	2,629.37	1,354.13	696.78	228.76	2,640.71	1,359.97	699.79	229.74	2,934.12	1,511.07	777.54	255.27
75	2,406.11	1,239.15	637.62	209.33	2,673.45	1,376.83	708.46	232.59	2,675.84	1,378.06	709.10	232.80	2,973.16	1,531.18	787.89	258.66
76	2,445.78	1,259.58	648.13	212.78	2,717.53	1,399.53	720.15	236.43	2,709.85	1,395.57	718.11	235.76	3,010.94	1,550.63	797.90	261.95
77	2,485.45	1,280.01	658.64	216.23	2,761.61	1,422.23	731.83	240.26	2,743.85	1,413.08	727.12	238.71	3,048.72	1,570.09	807.91	265.24
78	2,513.78	1,294.60	666.15	218.70	2,793.09	1,438.44	740.17	243.00	2,758.57	1,420.66	731.02	240.00	3,065.08	1,578.52	812.25	266.66
79	2,540.97	1,308.60	673.36	221.06	2,823.30	1,454.00	748.17	245.63	2,774.45	1,428.84	735.23	241.38	3,082.72	1,587.60	816.92	268.20
80	2,569.31	1,323.19	680.87	223.53	2,854.79	1,470.22	756.52	248.37	2,789.18	1,436.43	739.13	242.66	3,099.09	1,596.03	821.26	269.62
81	2,596.51	1,337.20	688.08	225.90	2,885.01	1,485.78	764.53	251.00	2,805.05	1,444.60	743.34	244.04	3,116.72	1,605.11	825.93	271.15
82	2,623.71	1,351.21	695.28	228.26	2,915.23	1,501.34	772.54	253.63	2,819.78	1,452.19	747.24	245.32	3,133.09	1,613.54	830.27	272.58
83	2,625.98	1,352.38	695.88	228.46	2,917.75	1,502.64	773.20	253.84	2,822.05	1,453.36	747.84	245.52	3,135.61	1,614.84	830.94	272.80
84	2,629.38	1,354.13	696.79	228.76	2,921.53	1,504.59	774.21	254.17	2,825.45	1,455.11	748.74	245.81	3,139.39	1,616.79	831.94	273.13
85+	2,631.65	1,355.30	697.39	228.95	2,924.05	1,505.89	774.87	254.39	2,827.72	1,456.28	749.35	246.01	3,141.91	1,618.08	832.61	273.35

2009		PLAN D RATES*												2009		
Under 65 Disability	FEMALE RATES								MALE RATES							
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
65	\$1,497.37	\$ 771.15	\$396.80	\$130.27	\$1,663.74	\$ 856.83	\$440.89	\$144.75	\$1,631.61	\$ 840.28	\$432.38	\$141.95	\$1,812.90	\$ 933.64	\$480.42	\$157.72
66	1,497.37	771.15	396.80	130.27	1,663.74	856.83	440.89	144.75	1,631.61	840.28	432.38	141.95	1,812.90	933.64	480.42	157.72
67	1,557.39	802.06	412.71	135.49	1,730.43	891.17	458.56	150.55	1,698.17	874.56	450.02	147.74	1,886.86	971.73	500.02	164.16
68	1,623.97	836.34	430.35	141.29	1,804.41	929.27	478.17	156.98	1,744.02	898.17	462.17	151.73	1,937.80	997.97	513.52	168.59
69	1,658.90	854.33	439.61	144.32	1,843.22	949.26	488.45	160.36	1,785.49	919.53	473.15	155.34	1,983.88	1,021.70	525.73	172.60
70	1,678.54	864.45	444.81	146.03	1,865.04	960.50	494.24	162.26	1,814.96	934.70	480.96	157.90	2,016.62	1,038.56	534.40	175.45
71	1,692.72	871.75	448.57	147.27	1,880.80	968.61	498.41	163.63	1,832.42	943.70	485.59	159.42	2,036.02	1,048.55	539.55	177.13
72	1,708.01	879.63	452.62	148.60	1,897.79	977.36	502.91	165.11	1,852.07	953.82	490.80	161.13	2,057.85	1,059.79	545.33	179.03
73	1,727.65	889.74	457.83	150.31	1,919.61	988.60	508.70	167.01	1,881.53	968.99	498.61	163.69	2,090.59	1,076.65	554.01	181.88
74	1,762.58	907.73	467.08	153.34	1,958.42	1,008.59	518.98	170.38	1,911.00	984.17	506.42	166.26	2,123.33	1,093.51	562.68	184.73
75	1,797.50	925.71	476.34	156.38	1,997.22	1,028.57	529.26	173.76	1,940.47	999.34	514.22	168.82	2,156.08	1,110.38	571.36	187.58
76	1,833.51	944.26	485.88	159.52	2,037.23	1,049.17	539.87	177.24	1,969.93	1,014.51	522.03	171.38	2,188.81	1,127.24	580.03	190.43
77	1,868.44	962.25	495.14	162.55	2,076.04	1,069.16	550.15	180.62	1,999.40	1,029.69	529.84	173.95	2,221.56	1,144.10	588.71	193.28
78	1,896.81	976.86	502.65	165.02	2,107.57	1,085.40	558.51	183.36	2,024.51	1,042.62	536.50	176.13	2,249.45	1,158.47	596.10	195.70
79	1,925.18	991.47	510.17	167.49	2,139.09	1,101.63	566.86	186.10	2,048.51	1,054.98	542.86	178.22	2,276.12	1,172.20	603.17	198.02
80	1,953.57	1,006.09	517.70	169.96	2,170.63	1,117.87	575.22	188.84	2,072.53	1,067.35	549.22	180.31	2,302.81	1,185.95	610.24	200.34
81	1,981.94	1,020.70	525.21	172.43	2,202.16	1,134.11	583.57	191.59	2,096.53	1,079.71	555.58	182.40	2,329.48	1,199.68	617.31	202.66
82	2,010.31	1,035.31	532.73	174.90	2,233.68	1,150.35	591.93	194.33	2,120.54	1,092.08	561.94	184.49	2,356.16	1,213.42	624.38	204.99
83	2,016.86	1,038.68	534.47	175.47	2,240.96	1,154.09	593.85	194.96	2,127.10	1,095.46	563.68	185.06	2,363.44	1,217.17	626.31	205.62
84	2,022.33	1,041.50	535.92	175.94	2,247.03	1,157.22	595.46	195.49	2,133.64	1,098.82	565.41	185.63	2,370.71	1,220.92	628.24	206.25
85+	2,028.87	1,044.87	537.65	176.51	2,254.30	1,160.96	597.39	196.12	2,140.19	1,102.20	567.15	186.20	2,377.99	1,224.66	630.17	206.89

*Add a one time \$20.00 application fee to the modal premium for the plan selected.

GEORGIA PREMIUMS FOR ZIP CODES (300-305, 308-316, 398, 399)

2009		PLAN E RATES*												2009		
Issue Age	FEMALE RATES								MALE RATES							
	Non Tobacco User				Tobacco User				Non Tobacco User				Tobacco User			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
Under 65 Disability	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	\$1,471.10	\$757.62	\$389.84	\$127.99	\$1,634.55	\$ 841.79	\$433.16	\$142.21	\$1,642.23	\$845.75	\$435.19	\$142.87	\$1,824.70	\$ 939.72	\$483.55	\$158.75
66	1,471.10	757.62	389.84	127.99	1,634.55	841.79	433.16	142.21	1,642.23	845.75	435.19	142.87	1,824.70	939.72	483.55	158.75
67	1,530.03	787.97	405.46	133.11	1,700.03	875.52	450.51	147.90	1,709.10	880.19	452.91	148.69	1,899.00	977.99	503.24	165.21
68	1,561.75	804.30	413.86	135.87	1,735.28	893.67	459.85	150.97	1,748.76	900.61	463.42	152.14	1,943.07	1,000.68	514.91	169.05
69	1,575.36	811.31	417.47	137.06	1,750.40	901.46	463.86	152.28	1,765.76	909.37	467.93	153.62	1,961.96	1,010.41	519.92	170.69
70	1,588.96	818.31	421.07	138.24	1,765.51	909.24	467.86	153.60	1,773.69	913.45	470.03	154.31	1,970.77	1,014.95	522.25	171.46
71	1,603.69	825.90	424.98	139.52	1,781.88	917.67	472.20	155.02	1,785.03	919.29	473.03	155.30	1,983.37	1,021.44	525.59	172.55
72	1,615.02	831.74	427.98	140.51	1,794.47	924.15	475.53	156.12	1,800.90	927.46	477.24	156.68	2,001.00	1,030.52	530.27	174.09
73	1,636.56	842.83	433.69	142.38	1,818.40	936.48	481.88	158.20	1,819.03	936.80	482.04	158.26	2,021.14	1,040.89	535.60	175.84
74	1,659.23	854.50	439.70	144.35	1,843.59	949.45	488.55	160.39	1,841.70	948.48	488.05	160.23	2,046.33	1,053.86	542.28	178.03
75	1,670.56	860.34	442.70	145.34	1,856.18	955.93	491.89	161.49	1,855.30	955.48	491.65	161.41	2,061.44	1,061.64	546.28	179.35
76	1,695.49	873.18	449.30	147.51	1,883.88	970.20	499.23	163.90	1,868.90	962.48	495.26	162.59	2,076.56	1,069.43	550.29	180.66
77	1,723.82	887.77	456.81	149.97	1,915.36	986.41	507.57	166.64	1,892.70	974.74	501.57	164.66	2,103.00	1,083.05	557.30	182.96
78	1,738.56	895.36	460.72	151.25	1,931.73	994.84	511.91	168.06	1,899.50	978.24	503.37	165.26	2,110.55	1,086.93	559.30	183.62
79	1,754.43	903.53	464.92	152.64	1,949.37	1,003.93	516.58	169.60	1,906.30	981.74	505.17	165.85	2,118.11	1,090.83	561.30	184.28
80	1,770.30	911.70	469.13	154.02	1,967.00	1,013.01	521.26	171.13	1,913.09	985.24	506.97	166.44	2,125.66	1,094.71	563.30	184.93
81	1,785.03	919.29	473.03	155.30	1,983.37	1,021.44	525.59	172.55	1,919.90	988.75	508.77	167.03	2,133.22	1,098.61	565.30	185.59
82	1,800.90	927.46	477.24	156.68	2,001.00	1,030.52	530.27	174.09	1,926.70	992.25	510.58	167.62	2,140.78	1,102.50	567.31	186.25
83	1,803.17	928.63	477.84	156.88	2,003.52	1,031.81	530.93	174.31	1,927.83	992.83	510.87	167.72	2,142.03	1,103.15	567.64	186.36
84	1,804.29	929.21	478.14	156.97	2,004.77	1,032.46	531.26	174.41	1,930.10	994.00	511.48	167.92	2,144.55	1,104.44	568.31	186.58
85+	1,805.44	929.80	478.44	157.07	2,006.04	1,033.11	531.60	174.53	1,932.36	995.17	512.08	168.12	2,147.07	1,105.74	568.97	186.80

2009		PLAN F RATES*												2009		
Under 65 Disability	FEMALE RATES								MALE RATES							
	Non Tobacco User				Tobacco User				Non Tobacco User				Tobacco User			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
Under 65 Disability	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	\$1,759.30	\$ 906.04	\$466.21	\$153.06	\$1,954.78	\$1,006.71	\$518.02	\$170.07	\$1,966.65	\$1,012.82	\$521.16	\$171.10	\$2,185.17	\$1,125.36	\$579.07	\$190.11
66	1,759.30	906.04	466.21	153.06	1,954.78	1,006.71	518.02	170.07	1,966.65	1,012.82	521.16	171.10	2,185.17	1,125.36	579.07	190.11
67	1,831.33	943.13	485.30	159.33	2,034.81	1,047.93	539.22	177.03	2,046.33	1,053.86	542.28	178.03	2,273.70	1,170.96	602.53	197.81
68	1,913.18	985.29	506.99	166.45	2,125.76	1,094.77	563.33	184.94	2,138.00	1,101.07	566.57	186.01	2,375.56	1,223.41	629.52	206.67
69	1,988.49	1,024.07	526.95	173.00	2,209.43	1,137.86	585.50	192.22	2,222.05	1,144.36	588.84	193.32	2,468.94	1,271.50	654.27	214.80
70	2,064.88	1,063.41	547.19	179.64	2,294.31	1,181.57	607.99	199.60	2,317.00	1,193.26	614.01	201.58	2,574.44	1,325.84	682.23	223.98
71	2,131.46	1,097.70	564.84	185.44	2,368.29	1,219.67	627.60	206.04	2,395.58	1,233.72	634.83	208.42	2,661.75	1,370.80	705.36	231.57
72	2,183.84	1,124.68	578.72	189.99	2,426.49	1,249.64	643.02	211.10	2,456.69	1,265.20	651.02	213.73	2,729.65	1,405.77	723.36	237.48
73	2,222.05	1,144.36	588.84	193.32	2,468.94	1,271.50	654.27	214.80	2,489.43	1,282.06	659.70	216.58	2,766.03	1,424.51	733.00	240.64
74	2,259.15	1,163.46	598.67	196.55	2,510.17	1,292.74	665.20	218.38	2,522.18	1,298.92	668.38	219.43	2,802.42	1,443.25	742.64	243.81
75	2,297.35	1,183.14	608.80	199.87	2,552.61	1,314.59	676.44	222.08	2,553.82	1,315.22	676.76	222.18	2,837.58	1,461.35	751.96	246.87
76	2,335.55	1,202.81	618.92	203.19	2,595.05	1,336.45	687.69	225.77	2,586.56	1,332.08	685.44	225.03	2,873.96	1,480.09	761.60	250.03
77	2,373.74	1,222.48	629.04	206.52	2,637.49	1,358.31	698.93	229.46	2,619.31	1,348.94	694.12	227.88	2,910.34	1,498.83	771.24	253.20
78	2,399.94	1,235.97	635.98	208.79	2,666.60	1,373.30	706.65	231.99	2,633.49	1,356.25	697.87	229.11	2,926.10	1,506.94	775.42	254.57
79	2,426.13	1,249.46	642.92	211.07	2,695.70	1,388.29	714.36	234.53	2,648.76	1,364.11	701.92	230.44	2,943.07	1,515.68	779.91	256.05
80	2,452.32	1,262.94	649.86	213.35	2,724.80	1,403.27	722.07	237.06	2,662.97	1,371.43	705.69	231.68	2,958.85	1,523.81	784.10	257.42
81	2,478.52	1,276.44	656.81	215.63	2,753.91	1,418.26	729.79	239.59	2,677.15	1,378.73	709.44	232.91	2,974.61	1,531.92	788.27	258.79
82	2,505.80	1,290.49	664.04	218.00	2,784.22	1,433.87	737.82	242.23	2,692.42	1,386.60	713.49	234.24	2,991.58	1,540.66	792.77	260.27
83	2,507.99	1,291.61	664.62	218.20	2,786.65	1,435.12	738.46	242.44	2,694.61	1,387.72	714.07	234.43	2,994.01	1,541.92	793.41	260.48
84	2,510.16	1,292.73	665.19	218.38	2,789.07	1,436.37	739.10	242.65	2,696.79	1,388.85	714.65	234.62	2,996.43	1,543.16	794.05	260.69
85+	2,512.34	1,293.86	665.77	218.57	2,791.49	1,437.62	739.74	242.86	2,700.06	1,390.53	715.52	234.91	3,000.07	1,545.04	795.02	261.01

*Add a one time \$20.00 application fee to the modal premium for the plan selected.

GEORGIA PREMIUMS FOR ZIP CODES (300-305, 308-316, 398, 399)

2009		PLAN G RATES*												2009		
Issue Age	FEMALE RATES								MALE RATES							
	Non Tobacco User				Tobacco User				Non Tobacco User				Tobacco User			
	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC	Annual	Semi-Annual	Quarterly	PAC
Under 65 Disability	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	\$1,486.46	\$ 765.53	\$393.91	\$129.32	\$1,651.62	\$ 850.58	\$437.68	\$143.69	\$1,619.60	\$ 834.09	\$429.19	\$140.91	\$1,799.56	\$ 926.77	\$476.88	\$156.56
66	1,486.46	765.53	393.91	129.32	1,651.62	850.58	437.68	143.69	1,619.60	834.09	429.19	140.91	1,799.56	926.77	476.88	156.56
67	1,546.48	796.44	409.82	134.54	1,718.31	884.93	455.35	149.49	1,686.18	868.38	446.84	146.70	1,873.53	964.87	496.49	163.00
68	1,616.33	832.41	428.33	140.62	1,795.92	924.90	475.92	156.25	1,761.48	907.16	466.79	153.25	1,957.20	1,007.96	518.66	170.28
69	1,643.61	846.46	435.56	142.99	1,826.23	940.51	483.95	158.88	1,796.41	925.15	476.05	156.29	1,996.01	1,027.95	528.94	173.65
70	1,656.70	853.20	439.03	144.13	1,840.78	948.00	487.81	160.15	1,811.68	933.02	480.10	157.62	2,012.98	1,036.68	533.44	175.13
71	1,667.63	858.83	441.92	145.08	1,852.92	954.25	491.02	161.20	1,823.69	939.20	483.28	158.66	2,026.32	1,043.55	536.97	176.29
72	1,681.81	866.13	445.68	146.32	1,868.68	962.37	495.20	162.58	1,838.96	947.06	487.32	159.99	2,043.29	1,052.29	541.47	177.77
73	1,714.55	882.99	454.36	149.17	1,905.06	981.11	504.84	165.74	1,867.35	961.69	494.85	162.46	2,074.83	1,068.54	549.83	180.51
74	1,749.48	900.98	463.61	152.20	1,943.87	1,001.09	515.13	169.12	1,896.81	976.86	502.65	165.02	2,107.57	1,085.40	558.51	183.36
75	1,785.49	919.53	473.15	155.34	1,983.88	1,021.70	525.73	172.60	1,926.28	992.03	510.46	167.59	2,140.31	1,102.26	567.18	186.21
76	1,820.41	937.51	482.41	158.38	2,022.68	1,041.68	536.01	175.97	1,955.75	1,007.21	518.27	170.15	2,173.05	1,119.12	575.86	189.06
77	1,855.34	955.50	491.67	161.41	2,061.49	1,061.67	546.29	179.35	1,985.22	1,022.39	526.08	172.71	2,205.80	1,135.99	584.54	191.90
78	1,883.71	970.11	499.18	163.88	2,093.01	1,077.90	554.65	182.09	2,009.22	1,034.75	532.44	174.80	2,232.47	1,149.72	591.60	194.22
79	1,911.00	984.17	506.42	166.26	2,123.33	1,093.51	562.68	184.73	2,033.24	1,047.12	538.81	176.89	2,259.15	1,163.46	598.67	196.55
80	1,939.37	998.78	513.93	168.73	2,154.86	1,109.75	571.04	187.47	2,057.24	1,059.48	545.17	178.98	2,285.82	1,177.20	605.74	198.87
81	1,967.75	1,013.39	521.45	171.19	2,186.39	1,125.99	579.39	190.22	2,081.26	1,071.85	551.53	181.07	2,312.51	1,190.94	612.82	201.19
82	1,996.13	1,028.01	528.97	173.66	2,217.92	1,142.23	587.75	192.96	2,105.26	1,084.21	557.89	183.16	2,339.18	1,204.68	619.88	203.51
83	2,001.58	1,030.81	530.42	174.14	2,223.98	1,145.35	589.35	193.49	2,111.81	1,087.58	559.63	183.73	2,346.45	1,208.42	621.81	204.14
84	2,008.13	1,034.19	532.15	174.71	2,231.26	1,149.10	591.28	194.12	2,118.37	1,090.96	561.37	184.30	2,353.74	1,212.18	623.74	204.78
85+	2,013.59	1,037.00	533.60	175.18	2,237.32	1,152.22	592.89	194.65	2,124.91	1,094.33	563.10	184.87	2,361.01	1,215.92	625.67	205.41

*Add a one time \$20.00 application fee to the modal premium for the plan selected.

THIS SPACE LEFT INTENTIONALLY BLANK.

PREMIUM INFORMATION

American National Life Insurance Company of Texas can only raise your premium if we raise the premium for all policies like yours in your state.

DISCLOSURES

Use this outline to compare benefits and premiums among plans.

READ YOUR CERTIFICATE VERY CAREFULLY

This is only an outline describing your certificate's most important features. The group policy is the insurance contract and the certificate issued to you is evidence of coverage under the policy. You must read the policy itself to understand all of the rights and duties of both you and your insurance company. You may review the group policy during normal business hours at the group policyholder's office.

RIGHT TO RETURN CERTIFICATE

If you find that you are not satisfied with your certificate, you may return it to ANTEX at the following address:

American National Life Insurance Company
of Texas
P.O. Box 1820
Galveston, TX 77553-1820

If you send the certificate back to us within 30 days after you receive it, we will treat the certificate as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

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

NOTICE

This certificate may not fully cover all of your medical costs. Neither ANTEX 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 enrollment application for the new certificate, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your certificate and refuse to pay any claims if you leave out or falsify important medical information.

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

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous service and supplies:</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after:</p> <ul style="list-style-type: none"> — While using 60 lifetime reserve days — Once lifetime reserve days are used: <ul style="list-style-type: none"> — Additional 365 days — Beyond the Additional 365 days 	<p>All but \$1,068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$1,068 (Part A Deductible)</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>All costs</p>
<p>BLOOD</p> <p>First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited co-insurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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.

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 tests, 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

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous service and supplies:</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after:</p> <ul style="list-style-type: none"> — While using 60 lifetime reserve days — Once lifetime reserve days are used: <ul style="list-style-type: none"> — Additional 365 days — Beyond the Additional 365 days 	<p>All but \$1,068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1,068 (Part A Deductible)</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>All costs</p>
<p>BLOOD</p> <p>First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited co-insurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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.

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 tests, 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

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous service and supplies:</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after:</p> <ul style="list-style-type: none"> — While using 60 lifetime reserve days — Once lifetime reserve days are used: <ul style="list-style-type: none"> — Additional 365 days — Beyond the Additional 365 days 	<p>All but \$1,068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1,068 (Part A Deductible)</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited co-insurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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.

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 tests, durable medical equipment: First \$135 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$135 (Part B Deductible) Generally 20%	\$0 \$0
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 \$135 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

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

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 service and supplies: First 60 days 61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the Additional 365 days	All but \$1,068 All but \$267 a day All but \$534 a day \$0 \$0	\$1,068 (Part A Deductible) \$267 a day \$534 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 co-insurance 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 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.

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 tests, durable medical equipment: First \$135 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B Deductible) \$0
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

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.

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
AT-HOME RECOVERY SERVICES — NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan:			
— Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
— Number of visits covered (Must be received within 8 weeks of last Medicare-approved visit)	\$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	
— Calendar year maximum	\$0	\$1,600	

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

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous service and supplies:</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after:</p> <ul style="list-style-type: none"> — While using 60 lifetime reserve days — Once lifetime reserve days are used: <ul style="list-style-type: none"> — Additional 365 days — Beyond the Additional 365 days 	<p>All but \$1,068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1,068 (Part A Deductible)</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited co-insurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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.

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 tests, 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

OTHER BENEFITS — NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>FOREIGN TRAVEL — NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</p> <p>First \$250 each calendar year</p> <p>Remainder of Charges</p>	<p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250</p> <p>20% and amounts over the \$50,000 lifetime maximum</p>
<p>PREVENTIVE MEDICAL CARE BENEFITS — NOT COVERED BY MEDICARE*** Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare</p> <p>First \$120 each calendar year</p> <p>Additional Charges</p>	<p>\$0</p> <p>\$0</p>	<p>\$120</p> <p>\$0</p>	<p>\$0</p> <p>All costs</p>

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

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 service and supplies: First 60 days 61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the Additional 365 days	All but \$1,068 All but \$267 a day All but \$534 a day \$0 \$0	\$1,068 (Part A Deductible) \$267 a day \$534 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital: First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 co-insurance 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 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.

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 tests, 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

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

MEDICARE (PART A) — HOSPITAL SERVICES — PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous service and supplies:</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after:</p> <ul style="list-style-type: none"> — While using 60 lifetime reserve days — Once lifetime reserve days are used: <ul style="list-style-type: none"> — Additional 365 days — Beyond the Additional 365 days 	<p>All but \$1,068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1,068 (Part A Deductible)</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD</p> <p>First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited co-insurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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.

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 tests, 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	80%	20%
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

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.

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
AT-HOME RECOVERY SERVICES — NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan:			
— Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
— Number of visits covered (Must be received within 8 weeks of last Medicare-approved visit)	\$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	
— Calendar year maximum	\$0	\$1,600	

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

2009 Index Georgia Medicare Supplement

Zip Codes	Rates (Page #)	Plan Description (Page #)
Plan A		13-14
306, 307, 317-319	4	
300-305, 308-316, 398, 399	8	
Plan B		15-16
306, 307, 317-319	4	
300-305, 308-316, 398, 399	8	
Plan C		17-19
306, 307, 317-319	5	
300-305, 308-316, 398, 399	9	
Plan D		20-22
306, 307, 317-319	5	
300-305, 308-316, 398, 399	9	
Plan E		23-25
306, 307, 317-319	6	
300-305, 308-316, 398, 399	10	
Plan F		26-28
306, 307, 317-319	6	
300-305, 308-316, 398, 399	10	
Plan G		29-31
306, 307, 317-319	7	
300-305, 308-316, 398, 399	11	
Summary of Benefits by Plan		1-3
Disclosures		12