



# Outline of coverage

## Medicare Supplement Insurance

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Benefit Plans A, B, F, High Deductible F, G, & N

**North Dakota**

Underwritten by  
**American Continental  
Insurance Company**

An Aetna Company

**[AetnaSeniorProducts.com](https://www.AetnaSeniorProducts.com)**

**AMERICAN CONTINENTAL INSURANCE COMPANY**  
**OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE**  
**BENEFIT PLANS AVAILABLE: A, B, F, HF, G, & N**

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and High Deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G <sup>1</sup>	K	L	M	N	C	F <sup>1</sup>
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply <sup>3</sup>	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2024 <sup>2</sup>					<b>\$7,060<sup>2</sup></b>	<b>\$3,530<sup>2</sup></b>				

<sup>1</sup> Plans F and G also have a high deductible option, which require first paying a plan deductible of **\$2,800** before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

<sup>2</sup> Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

<sup>3</sup> Plan N pays 100% of the Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that do not result in an inpatient admission.

**American Continental Insurance Company**  
**Annual Attained Age Premiums**  
**For Use in ZIP Codes: Entire State**  
**Female Rates**  
**Rates Effective 6/1/2023**

ATTAINED AGE	NON-TOBACCO					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,699	2,141	2,982	830	1,629	1,188
66	1,699	2,141	2,982	830	1,629	1,188
67	1,699	2,141	2,982	830	1,629	1,188
68	1,771	2,230	3,104	865	1,697	1,238
69	1,849	2,332	3,224	898	1,772	1,294
70	1,923	2,425	3,342	931	1,843	1,346
71	1,997	2,515	3,458	965	1,914	1,397
72	2,066	2,603	3,570	995	1,983	1,445
73	2,132	2,684	3,665	1,021	2,045	1,491
74	2,196	2,763	3,760	1,047	2,102	1,533
75	2,247	2,834	3,845	1,071	2,157	1,573
76	2,300	2,897	3,919	1,095	2,206	1,609
77	2,349	2,959	3,988	1,110	2,253	1,646
78	2,391	3,015	4,049	1,130	2,297	1,676
79	2,439	3,070	4,106	1,144	2,337	1,704
80	2,478	3,119	4,157	1,159	2,375	1,732
81	2,511	3,159	4,211	1,174	2,410	1,757
82	2,544	3,205	4,264	1,191	2,440	1,781
83	2,581	3,247	4,315	1,204	2,470	1,803
84	2,608	3,286	4,366	1,218	2,502	1,827
85	2,638	3,328	4,415	1,232	2,532	1,847
86	2,670	3,363	4,460	1,244	2,561	1,867
87	2,697	3,399	4,506	1,255	2,585	1,887
88	2,726	3,434	4,543	1,268	2,615	1,907
89	2,749	3,467	4,582	1,278	2,639	1,925
90	2,773	3,497	4,623	1,289	2,661	1,943
91	2,798	3,525	4,659	1,298	2,684	1,958
92	2,819	3,553	4,689	1,306	2,704	1,970
93	2,837	3,577	4,717	1,317	2,724	1,986
94	2,860	3,600	4,741	1,321	2,741	1,998
95	2,874	3,618	4,768	1,329	2,758	2,011
96	2,892	3,643	4,791	1,336	2,772	2,024
97	2,909	3,664	4,819	1,345	2,788	2,034
98	2,924	3,684	4,842	1,349	2,804	2,046
99	2,943	3,706	4,866	1,357	2,824	2,059

ATTAINED AGE	TOBACCO					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,887	2,379	3,312	923	1,809	1,321
66	1,887	2,379	3,312	923	1,809	1,321
67	1,887	2,379	3,312	923	1,809	1,321
68	1,968	2,479	3,448	961	1,886	1,377
69	2,055	2,588	3,587	1,000	1,974	1,439
70	2,135	2,693	3,715	1,034	2,050	1,494
71	2,215	2,797	3,845	1,071	2,128	1,551
72	2,297	2,893	3,963	1,104	2,202	1,606
73	2,366	2,983	4,074	1,135	2,271	1,657
74	2,439	3,070	4,177	1,165	2,337	1,705
75	2,495	3,146	4,274	1,192	2,394	1,748
76	2,555	3,220	4,351	1,213	2,449	1,788
77	2,611	3,287	4,429	1,234	2,503	1,827
78	2,660	3,353	4,500	1,255	2,552	1,862
79	2,706	3,410	4,560	1,270	2,596	1,893
80	2,749	3,467	4,619	1,288	2,639	1,925
81	2,788	3,513	4,677	1,305	2,677	1,953
82	2,827	3,563	4,738	1,321	2,713	1,979
83	2,863	3,610	4,794	1,336	2,747	2,003
84	2,899	3,653	4,852	1,350	2,782	2,028
85	2,932	3,696	4,906	1,367	2,814	2,051
86	2,966	3,737	4,956	1,382	2,845	2,077
87	2,998	3,775	5,003	1,394	2,875	2,098
88	3,026	3,815	5,051	1,408	2,904	2,117
89	3,056	3,851	5,092	1,421	2,931	2,139
90	3,086	3,884	5,136	1,432	2,957	2,158
91	3,108	3,916	5,175	1,442	2,982	2,173
92	3,131	3,947	5,212	1,454	3,004	2,192
93	3,154	3,973	5,243	1,461	3,025	2,206
94	3,176	3,998	5,271	1,471	3,045	2,223
95	3,194	4,025	5,298	1,476	3,062	2,236
96	3,210	4,048	5,324	1,484	3,081	2,247
97	3,232	4,072	5,352	1,493	3,098	2,260
98	3,250	4,094	5,381	1,500	3,117	2,273
99	3,270	4,120	5,409	1,507	3,136	2,288

The above rates do not include the \$20 application fee.

If applying during Open Enrollment or Guaranteed Issue Period, use Non-Tobacco rates.

**Modal factors**

Semi-annual .....0.5200  
Quarterly .....0.2650  
Monthly .....0.0833

# American Continental Insurance Company

## Annual Attained Age Premiums For Use in ZIP Codes: Entire State Male Rates

Rates Effective 6/1/2023

ATTAINED AGE	NON-TOBACCO					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,954	2,460	3,429	955	1,873	1,368
66	1,954	2,460	3,429	955	1,873	1,368
67	1,954	2,460	3,429	955	1,873	1,368
68	2,034	2,566	3,570	995	1,952	1,424
69	2,125	2,681	3,707	1,033	2,041	1,489
70	2,212	2,786	3,847	1,073	2,122	1,548
71	2,298	2,893	3,980	1,109	2,202	1,606
72	2,377	2,994	4,106	1,144	2,278	1,662
73	2,450	3,088	4,213	1,174	2,349	1,715
74	2,521	3,178	4,327	1,207	2,420	1,764
75	2,585	3,256	4,423	1,233	2,479	1,810
76	2,644	3,331	4,506	1,255	2,535	1,850
77	2,700	3,402	4,582	1,278	2,593	1,890
78	2,756	3,469	4,657	1,298	2,641	1,927
79	2,801	3,528	4,723	1,317	2,686	1,960
80	2,848	3,587	4,780	1,334	2,729	1,992
81	2,886	3,640	4,842	1,349	2,768	2,020
82	2,925	3,686	4,906	1,367	2,807	2,047
83	2,965	3,737	4,963	1,383	2,842	2,072
84	2,999	3,777	5,021	1,400	2,876	2,099
85	3,037	3,825	5,077	1,416	2,910	2,124
86	3,070	3,867	5,128	1,429	2,944	2,148
87	3,102	3,910	5,181	1,445	2,976	2,170
88	3,133	3,947	5,227	1,459	3,006	2,193
89	3,159	3,986	5,278	1,471	3,035	2,214
90	3,192	4,021	5,318	1,481	3,061	2,232
91	3,219	4,054	5,354	1,493	3,086	2,252
92	3,239	4,085	5,391	1,502	3,110	2,268
93	3,265	4,115	5,427	1,514	3,130	2,285
94	3,285	4,141	5,456	1,522	3,152	2,298
95	3,303	4,162	5,486	1,527	3,171	2,313
96	3,324	4,187	5,511	1,537	3,188	2,326
97	3,343	4,210	5,538	1,544	3,206	2,339
98	3,363	4,237	5,568	1,552	3,225	2,355
99	3,384	4,262	5,596	1,557	3,244	2,368

ATTAINED AGE	TOBACCO					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	2,173	2,734	3,808	1,061	2,081	1,520
66	2,173	2,734	3,808	1,061	2,081	1,520
67	2,173	2,734	3,808	1,061	2,081	1,520
68	2,263	2,850	3,964	1,104	2,169	1,583
69	2,360	2,977	4,122	1,149	2,266	1,654
70	2,458	3,096	4,274	1,192	2,356	1,720
71	2,552	3,214	4,423	1,233	2,447	1,784
72	2,638	3,328	4,560	1,270	2,532	1,847
73	2,724	3,431	4,683	1,306	2,611	1,904
74	2,801	3,528	4,804	1,339	2,686	1,960
75	2,872	3,617	4,911	1,370	2,753	2,010
76	2,940	3,703	5,004	1,397	2,818	2,057
77	3,000	3,785	5,092	1,421	2,876	2,099
78	3,057	3,852	5,174	1,441	2,933	2,140
79	3,112	3,920	5,245	1,461	2,984	2,178
80	3,159	3,984	5,311	1,481	3,034	2,213
81	3,208	4,042	5,382	1,500	3,079	2,245
82	3,251	4,095	5,449	1,522	3,119	2,274
83	3,295	4,148	5,515	1,539	3,158	2,304
84	3,333	4,199	5,579	1,555	3,198	2,334
85	3,374	4,249	5,641	1,573	3,235	2,359
86	3,410	4,300	5,701	1,590	3,272	2,386
87	3,445	4,342	5,755	1,604	3,307	2,411
88	3,482	4,385	5,809	1,618	3,340	2,437
89	3,513	4,426	5,861	1,634	3,370	2,459
90	3,542	4,466	5,906	1,646	3,403	2,482
91	3,576	4,505	5,953	1,658	3,427	2,502
92	3,603	4,540	5,993	1,669	3,455	2,522
93	3,627	4,568	6,029	1,680	3,479	2,538
94	3,651	4,598	6,062	1,691	3,501	2,554
95	3,672	4,628	6,094	1,699	3,522	2,568
96	3,694	4,655	6,125	1,706	3,541	2,584
97	3,716	4,682	6,152	1,716	3,564	2,600
98	3,737	4,708	6,186	1,726	3,586	2,615
99	3,758	4,736	6,216	1,731	3,606	2,631

The above rates do not include the \$20 application fee.

If applying during Open Enrollment or Guaranteed Issue Period, use Non-Tobacco rates.

### Modal factors

Semi-annual .....0.5200  
Quarterly .....0.2650  
Monthly .....0.0833

## **PREMIUM INFORMATION**

American Continental Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state. Premiums for this policy will increase due to the increase in your age. Upon attainment of an age requiring a rate increase, the renewal premium for the policy will be the renewal premium then in effect for your attained age. Other policies may be provided with Issue Age rating and do not increase with age. You should compare Issue Age with Attained Age policies.

Premiums payable other than annually will be determined according to the following factors:

Semi-annual: 0.5200 Quarterly: 0.2650 Monthly EFT: 0.0833.

## **DISCLOSURES**

Use this outline to compare benefits and premium among policies.

### **READ YOUR POLICY VERY CAREFULLY**

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

### **RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to American Continental Insurance Company, P.O. Box 14770, Lexington, KY 40512-4770. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

### **POLICY REPLACEMENT**

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

## **NOTICE**

The policy may not cover all of your medical costs. Neither American Continental Insurance Company nor its agents are connected with Medicare.

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

### **COMPLETE ANSWERS ARE VERY IMPORTANT**

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

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

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

## PLAN A

### MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$0	\$1,632 (Part A Deductible)
61st thru 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$816 a day	\$816 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
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$204 a day	\$0	Up to \$204 a day
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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

## PLAN A

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

\*Once you have been billed \$240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES –</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

## PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE –</b> MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$1,632 (Part A Deductible)	\$0
61st thru 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$816 a day	\$816 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
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$204 a day	\$0	Up to \$204 a day
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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



## PLAN B

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

\*Once you have been billed \$240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES –</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

## PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE –</b> MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$1,632 (Part A Deductible)	\$0
61st thru 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$816 a day	\$816 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
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$204 a day	Up to \$204 a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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

## PLAN F

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

\*Once you have been billed \$240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES –</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$240 (Part B Deductible)	\$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare-Approved amounts*	\$0	\$240 (Part B Deductible)	\$0
Remainder of Medicare-Approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE –</b> MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$240 (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
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

## HIGH DEDUCTIBLE 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.

**\*\*This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,800 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$2,800. 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 \$2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2,800 DEDUCTIBLE** YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$1,632 (Part A Deductible)	\$0
61st thru 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$816 a day	\$816 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
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$204 a day	Up to \$204 a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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

## HIGH DEDUCTIBLE PLAN F

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

\*Once you have been billed \$240 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 \$2,800 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$2,800. 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 \$2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2,800 DEDUCTIBLE** YOU PAY
<b>MEDICAL EXPENSES –</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$240 (Part B Deductible)	\$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare-Approved amounts*	\$0	\$240 (Part B Deductible)	\$0
Remainder of Medicare-Approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

## HIGH DEDUCTIBLE PLAN F

### PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2,800 DEDUCTIBLE** YOU PAY
<b>HOME HEALTH CARE – MEDICARE APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$240 (Part B Deductible)	\$0
Remainder of Medicare-Approved amounts	80%	20%	\$0

### OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2,800 DEDUCTIBLE** YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

## 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$1,632 (Part A Deductible)	\$0
61st thru 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$816 a day	\$816 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
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$204 a day	Up to \$204 a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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



## PLAN G

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

\*Once you have been billed \$240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES –</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE –</b> MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	\$0

**PLAN G**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

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

## 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$1,632 (Part A Deductible)	\$0
61st thru 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$816 a day	\$816 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
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$204 a day	Up to \$204 a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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

## PLAN N

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

\*Once you have been billed \$240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES –</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (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.
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PLAN N**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE – MEDICARE APPROVED SERVICES</b>			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	\$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

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