Outline of coverage

Medicare Supplement Insurance

Benefit plans: A, B, F High Deductible F, G & N

New Mexico

Underwritten by

American Continental Insurance Company

An Aetna Company

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ACIMS05030NM

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Rates effective: 10/2021 B

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. 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[1]	K	L	M	N	C	F[1]
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[3]	✔	✔
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 2022[2]					**$6,620[2]**	**$3,310[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,490 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.

[2] 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.

[3] 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: 870-872
Female Rates

Rates Effective 10/01/2021

Attained Age	Preferred						Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,741	2,195	2,645	1,002	1,514	1,119	1,936	2,440	2,939	1,113	1,682	1,244
66	1,741	2,195	2,645	1,002	1,514	1,119	1,936	2,440	2,939	1,113	1,682	1,244
67	1,741	2,195	2,645	1,002	1,514	1,119	1,936	2,440	2,939	1,113	1,682	1,244
68	1,816	2,286	2,755	1,043	1,577	1,166	2,015	2,539	3,058	1,160	1,752	1,297
69	1,895	2,389	2,860	1,086	1,646	1,218	2,107	2,654	3,183	1,207	1,832	1,355
70	1,970	2,487	2,967	1,126	1,711	1,267	2,191	2,759	3,296	1,247	1,904	1,408
71	2,047	2,577	3,069	1,162	1,777	1,314	2,272	2,867	3,412	1,292	1,976	1,460
72	2,119	2,670	3,166	1,201	1,838	1,361	2,353	2,966	3,518	1,332	2,044	1,512
73	2,184	2,754	3,252	1,234	1,898	1,403	2,424	3,058	3,614	1,371	2,108	1,560
74	2,251	2,832	3,335	1,264	1,951	1,444	2,499	3,147	3,707	1,407	2,171	1,606
75	2,304	2,903	3,412	1,292	2,001	1,482	2,561	3,228	3,791	1,437	2,224	1,645
76	2,359	2,971	3,479	1,321	2,048	1,515	2,618	3,302	3,863	1,464	2,277	1,683
77	2,407	3,032	3,540	1,342	2,092	1,549	2,675	3,372	3,929	1,492	2,324	1,720
78	2,453	3,092	3,592	1,364	2,134	1,579	2,727	3,436	3,992	1,513	2,371	1,753
79	2,499	3,147	3,643	1,381	2,171	1,605	2,777	3,498	4,047	1,533	2,410	1,782
80	2,537	3,199	3,689	1,399	2,206	1,631	2,821	3,552	4,100	1,553	2,449	1,812
81	2,574	3,241	3,736	1,416	2,236	1,654	2,859	3,605	4,150	1,574	2,484	1,838
82	2,606	3,288	3,785	1,435	2,265	1,677	2,899	3,652	4,204	1,595	2,517	1,863
83	2,644	3,331	3,828	1,454	2,295	1,698	2,936	3,697	4,254	1,612	2,551	1,887
84	2,675	3,371	3,873	1,471	2,324	1,720	2,973	3,745	4,306	1,633	2,583	1,910
85	2,707	3,411	3,917	1,488	2,350	1,739	3,005	3,789	4,352	1,650	2,613	1,932
86	2,737	3,447	3,955	1,500	2,377	1,758	3,041	3,832	4,397	1,666	2,643	1,955
87	2,765	3,485	3,998	1,515	2,404	1,777	3,071	3,871	4,439	1,682	2,670	1,975
88	2,792	3,521	4,035	1,531	2,427	1,796	3,106	3,911	4,483	1,699	2,697	1,995
89	2,821	3,552	4,065	1,541	2,449	1,812	3,133	3,947	4,522	1,713	2,721	2,013
90	2,842	3,582	4,102	1,554	2,471	1,830	3,164	3,984	4,558	1,727	2,746	2,031
91	2,868	3,618	4,134	1,568	2,491	1,843	3,187	4,014	4,590	1,741	2,770	2,046
92	2,888	3,643	4,161	1,577	2,510	1,856	3,212	4,045	4,625	1,757	2,790	2,064
93	2,907	3,668	4,187	1,590	2,529	1,871	3,233	4,076	4,651	1,764	2,809	2,077
94	2,930	3,691	4,209	1,595	2,545	1,882	3,256	4,101	4,678	1,774	2,827	2,092
95	2,947	3,710	4,230	1,606	2,561	1,894	3,274	4,128	4,700	1,782	2,843	2,105
96	2,966	3,733	4,253	1,612	2,575	1,906	3,292	4,149	4,725	1,790	2,860	2,116
97	2,981	3,754	4,275	1,622	2,590	1,914	3,314	4,174	4,750	1,802	2,877	2,127
98	2,997	3,778	4,298	1,631	2,605	1,927	3,333	4,196	4,775	1,809	2,895	2,140
99	3,017	3,802	4,317	1,637	2,620	1,938	3,353	4,225	4,798	1,819	2,913	2,155

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

American Continental Insurance Company

Annual Attained Age Premiums
For Use in ZIP Codes: 870-872
Male Rates

Rates Effective 10/01/2021

Attained Age	Preferred						Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	2,003	2,523	3,043	1,156	1,740	1,287	2,225	2,803	3,377	1,281	1,934	1,432
66	2,003	2,523	3,043	1,156	1,740	1,287	2,225	2,803	3,377	1,281	1,934	1,432
67	2,003	2,523	3,043	1,156	1,740	1,287	2,225	2,803	3,377	1,281	1,934	1,432
68	2,086	2,632	3,166	1,201	1,812	1,341	2,317	2,920	3,519	1,332	2,014	1,490
69	2,180	2,749	3,293	1,247	1,895	1,402	2,420	3,052	3,656	1,388	2,105	1,557
70	2,269	2,857	3,413	1,293	1,971	1,457	2,521	3,174	3,791	1,437	2,191	1,620
71	2,355	2,966	3,530	1,342	2,044	1,512	2,617	3,294	3,924	1,489	2,272	1,681
72	2,437	3,069	3,643	1,381	2,116	1,565	2,707	3,411	4,047	1,533	2,349	1,739
73	2,513	3,167	3,739	1,416	2,181	1,615	2,792	3,518	4,153	1,576	2,425	1,794
74	2,584	3,257	3,837	1,458	2,246	1,662	2,871	3,620	4,263	1,618	2,494	1,846
75	2,651	3,337	3,924	1,489	2,304	1,703	2,942	3,709	4,359	1,655	2,556	1,893
76	2,709	3,417	3,998	1,515	2,356	1,741	3,012	3,793	4,443	1,684	2,616	1,936
77	2,767	3,487	4,065	1,541	2,406	1,780	3,075	3,880	4,522	1,713	2,672	1,976
78	2,822	3,559	4,133	1,568	2,450	1,815	3,135	3,951	4,589	1,740	2,723	2,015
79	2,871	3,620	4,190	1,590	2,494	1,846	3,190	4,024	4,653	1,764	2,771	2,050
80	2,920	3,677	4,241	1,609	2,534	1,875	3,241	4,084	4,712	1,785	2,816	2,083
81	2,959	3,730	4,298	1,631	2,573	1,902	3,289	4,146	4,775	1,809	2,859	2,114
82	3,002	3,779	4,352	1,650	2,606	1,928	3,334	4,198	4,836	1,836	2,897	2,141
83	3,040	3,830	4,403	1,671	2,640	1,950	3,378	4,255	4,897	1,857	2,934	2,170
84	3,074	3,873	4,456	1,691	2,672	1,976	3,418	4,304	4,950	1,878	2,970	2,196
85	3,112	3,918	4,506	1,707	2,703	2,001	3,459	4,359	5,007	1,898	3,004	2,221
86	3,147	3,964	4,550	1,725	2,733	2,023	3,498	4,408	5,055	1,918	3,039	2,246
87	3,178	4,010	4,595	1,742	2,762	2,043	3,534	4,452	5,104	1,936	3,070	2,271
88	3,215	4,046	4,638	1,758	2,791	2,065	3,568	4,496	5,155	1,953	3,102	2,294
89	3,241	4,086	4,681	1,774	2,816	2,085	3,605	4,538	5,201	1,970	3,129	2,316
90	3,273	4,121	4,715	1,785	2,842	2,102	3,632	4,581	5,242	1,986	3,158	2,336
91	3,298	4,154	4,751	1,802	2,864	2,119	3,666	4,618	5,282	2,003	3,184	2,357
92	3,321	4,187	4,782	1,815	2,887	2,135	3,696	4,650	5,315	2,013	3,207	2,374
93	3,351	4,219	4,817	1,825	2,906	2,151	3,722	4,684	5,349	2,028	3,229	2,389
94	3,366	4,245	4,842	1,838	2,926	2,164	3,744	4,716	5,376	2,040	3,252	2,405
95	3,387	4,268	4,866	1,845	2,942	2,178	3,766	4,746	5,403	2,048	3,270	2,419
96	3,406	4,294	4,889	1,853	2,959	2,190	3,788	4,771	5,435	2,061	3,288	2,433
97	3,428	4,317	4,913	1,864	2,977	2,203	3,810	4,800	5,461	2,071	3,310	2,447
98	3,447	4,344	4,942	1,875	2,995	2,216	3,832	4,828	5,488	2,081	3,329	2,462
99	3,468	4,371	4,966	1,882	3,013	2,230	3,853	4,855	5,517	2,090	3,349	2,476

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

American Continental Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of State

Female Rates

Rates Effective 10/01/2021

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,466	1,848	2,227	844	1,275	942
66	1,466	1,848	2,227	844	1,275	942
67	1,466	1,848	2,227	844	1,275	942
68	1,530	1,925	2,320	878	1,328	982
69	1,596	2,012	2,409	914	1,386	1,026
70	1,659	2,094	2,498	948	1,441	1,067
71	1,724	2,170	2,585	978	1,497	1,106
72	1,784	2,248	2,666	1,011	1,548	1,146
73	1,839	2,319	2,738	1,039	1,598	1,182
74	1,895	2,385	2,808	1,065	1,643	1,216
75	1,940	2,445	2,874	1,088	1,685	1,248
76	1,986	2,502	2,930	1,112	1,725	1,276
77	2,027	2,554	2,981	1,130	1,762	1,305
78	2,066	2,604	3,025	1,149	1,797	1,330
79	2,104	2,650	3,068	1,163	1,828	1,351
80	2,137	2,694	3,106	1,178	1,858	1,374
81	2,167	2,730	3,146	1,193	1,883	1,393
82	2,194	2,769	3,187	1,209	1,907	1,412
83	2,226	2,805	3,223	1,224	1,933	1,430
84	2,253	2,838	3,262	1,238	1,957	1,449
85	2,279	2,873	3,298	1,253	1,979	1,465
86	2,305	2,902	3,330	1,263	2,002	1,480
87	2,329	2,934	3,366	1,276	2,024	1,497
88	2,351	2,965	3,398	1,290	2,044	1,512
89	2,375	2,991	3,423	1,298	2,062	1,526
90	2,394	3,016	3,454	1,309	2,081	1,541
91	2,415	3,046	3,482	1,320	2,098	1,552
92	2,432	3,068	3,504	1,328	2,114	1,563
93	2,448	3,089	3,526	1,339	2,130	1,575
94	2,467	3,108	3,545	1,343	2,143	1,585
95	2,482	3,124	3,562	1,352	2,157	1,595
96	2,498	3,143	3,582	1,358	2,168	1,605
97	2,510	3,162	3,600	1,366	2,181	1,612
98	2,524	3,182	3,619	1,374	2,194	1,622
99	2,541	3,202	3,635	1,378	2,206	1,632

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,630	2,054	2,475	938	1,416	1,047
66	1,630	2,054	2,475	938	1,416	1,047
67	1,630	2,054	2,475	938	1,416	1,047
68	1,697	2,138	2,575	977	1,475	1,092
69	1,774	2,235	2,680	1,016	1,542	1,141
70	1,845	2,323	2,775	1,050	1,603	1,186
71	1,914	2,414	2,874	1,088	1,664	1,230
72	1,982	2,498	2,962	1,122	1,722	1,274
73	2,042	2,575	3,043	1,154	1,775	1,314
74	2,104	2,650	3,122	1,185	1,828	1,352
75	2,157	2,718	3,193	1,210	1,873	1,386
76	2,205	2,781	3,253	1,233	1,918	1,418
77	2,253	2,839	3,309	1,256	1,957	1,449
78	2,296	2,894	3,362	1,274	1,997	1,476
79	2,338	2,946	3,408	1,291	2,030	1,501
80	2,375	2,991	3,453	1,308	2,062	1,526
81	2,407	3,036	3,494	1,326	2,092	1,548
82	2,442	3,075	3,540	1,343	2,119	1,569
83	2,473	3,114	3,582	1,358	2,148	1,589
84	2,503	3,154	3,626	1,375	2,175	1,608
85	2,530	3,190	3,665	1,390	2,200	1,627
86	2,561	3,227	3,702	1,403	2,226	1,646
87	2,586	3,260	3,738	1,417	2,248	1,663
88	2,615	3,294	3,775	1,430	2,271	1,680
89	2,638	3,324	3,808	1,442	2,291	1,695
90	2,665	3,355	3,838	1,454	2,313	1,710
91	2,684	3,380	3,866	1,466	2,333	1,723
92	2,705	3,406	3,894	1,479	2,350	1,738
93	2,722	3,432	3,917	1,486	2,366	1,749
94	2,742	3,454	3,939	1,494	2,381	1,762
95	2,757	3,476	3,958	1,501	2,394	1,773
96	2,772	3,494	3,979	1,507	2,408	1,782
97	2,790	3,515	4,000	1,518	2,422	1,791
98	2,806	3,534	4,021	1,523	2,438	1,802
99	2,823	3,558	4,040	1,532	2,453	1,814

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

American Continental Insurance Company

Annual Attained Age Premiums
For Use in ZIP Codes: Rest of State
Male Rates

Rates Effective 10/01/2021

Attained Age	Preferred						Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N		Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,686	2,125	2,562	974	1,466	1,084	65	1,874	2,360	2,844	1,078	1,629	1,206
66	1,686	2,125	2,562	974	1,466	1,084	66	1,874	2,360	2,844	1,078	1,629	1,206
67	1,686	2,125	2,562	974	1,466	1,084	67	1,874	2,360	2,844	1,078	1,629	1,206
68	1,757	2,217	2,666	1,011	1,526	1,130	68	1,951	2,459	2,963	1,122	1,696	1,254
69	1,836	2,315	2,773	1,050	1,596	1,181	69	2,038	2,570	3,078	1,169	1,773	1,311
70	1,910	2,406	2,874	1,089	1,660	1,227	70	2,123	2,673	3,193	1,210	1,845	1,364
71	1,983	2,498	2,973	1,130	1,722	1,274	71	2,204	2,774	3,305	1,254	1,914	1,415
72	2,052	2,585	3,068	1,163	1,782	1,318	72	2,279	2,873	3,408	1,291	1,978	1,465
73	2,116	2,667	3,149	1,193	1,837	1,360	73	2,351	2,962	3,498	1,327	2,042	1,510
74	2,176	2,742	3,231	1,228	1,891	1,399	74	2,418	3,048	3,590	1,362	2,100	1,554
75	2,232	2,810	3,305	1,254	1,940	1,434	75	2,478	3,123	3,670	1,394	2,153	1,594
76	2,282	2,878	3,366	1,276	1,984	1,466	76	2,536	3,194	3,742	1,418	2,203	1,630
77	2,330	2,937	3,423	1,298	2,026	1,499	77	2,590	3,267	3,808	1,442	2,250	1,664
78	2,377	2,997	3,481	1,320	2,063	1,529	78	2,640	3,327	3,864	1,466	2,293	1,697
79	2,418	3,048	3,528	1,339	2,100	1,554	79	2,686	3,389	3,918	1,486	2,334	1,726
80	2,459	3,097	3,571	1,355	2,134	1,579	80	2,730	3,439	3,968	1,503	2,371	1,754
81	2,492	3,141	3,619	1,374	2,166	1,602	81	2,770	3,491	4,021	1,523	2,407	1,780
82	2,528	3,182	3,665	1,390	2,194	1,623	82	2,807	3,535	4,072	1,546	2,439	1,803
83	2,560	3,226	3,708	1,407	2,223	1,642	83	2,845	3,583	4,124	1,564	2,470	1,827
84	2,589	3,262	3,752	1,424	2,250	1,664	84	2,878	3,624	4,168	1,582	2,501	1,850
85	2,621	3,299	3,794	1,438	2,276	1,685	85	2,913	3,670	4,216	1,598	2,530	1,870
86	2,650	3,338	3,831	1,453	2,302	1,703	86	2,946	3,712	4,257	1,615	2,559	1,891
87	2,676	3,377	3,870	1,467	2,326	1,720	87	2,976	3,749	4,298	1,630	2,586	1,912
88	2,707	3,407	3,906	1,481	2,350	1,739	88	3,005	3,786	4,341	1,645	2,612	1,932
89	2,730	3,441	3,942	1,494	2,371	1,756	89	3,036	3,822	4,380	1,659	2,635	1,950
90	2,756	3,470	3,970	1,503	2,394	1,770	90	3,058	3,858	4,414	1,673	2,659	1,967
91	2,778	3,498	4,001	1,518	2,412	1,785	91	3,087	3,889	4,448	1,686	2,682	1,985
92	2,797	3,526	4,027	1,529	2,431	1,798	92	3,112	3,916	4,476	1,695	2,701	1,999
93	2,822	3,553	4,056	1,537	2,447	1,811	93	3,134	3,944	4,504	1,708	2,719	2,012
94	2,834	3,574	4,078	1,548	2,464	1,822	94	3,153	3,971	4,527	1,718	2,738	2,026
95	2,852	3,594	4,098	1,554	2,478	1,834	95	3,171	3,997	4,550	1,725	2,754	2,037
96	2,868	3,616	4,117	1,560	2,492	1,844	96	3,190	4,018	4,577	1,735	2,769	2,049
97	2,886	3,635	4,138	1,570	2,507	1,855	97	3,208	4,042	4,598	1,744	2,787	2,061
98	2,902	3,658	4,162	1,579	2,522	1,866	98	3,227	4,066	4,622	1,753	2,803	2,074
99	2,920	3,681	4,182	1,585	2,538	1,878	99	3,245	4,089	4,646	1,760	2,820	2,085

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

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
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,556	$0	$1,556 (Part A Deductible)
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $194.50 a day	$0	Up to $194.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$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 $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$0	$233 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
• While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
• Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
• Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $194.50 a day	$0	Up to $194.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$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 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 $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$0	$233 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	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 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 $233 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $233 of Medicare-Approved amounts*	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$233 (Part B Deductible)	$0
• Remainder of Medicare Approved amounts	80%	20%	$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE 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 $2,490 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,490. 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 $2,490 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after •While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
•Once lifetime reserve days are used: •Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	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 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 $233 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 $2,490 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,490. 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 $2,490 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE*** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $233 of Medicare-Approved amounts*	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$233 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,490 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $233 of Medicare Approved amounts*	$0	$233 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,490 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$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 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 $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$0	$233 (Part B Deductible)
• Remainder of Medicare Approved amounts	80%	20%	$0

PLAN G

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$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 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 $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 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.
Part B Excess Charges (Above Medicare-Approved amounts)	$0	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $233 of Medicare-Approved amounts*	$0	$0	$233 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
• First $233 of Medicare Approved amounts*	$0	$0	$233 (Part B Deductible)
• Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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