



Outline of coverage

Medicare Supplement Insurance

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

West Virginia

Underwritten by

**American Continental
Insurance Company**

An Aetna Company

[AetnaSeniorProducts.com](https://www.aetna.com/seniorproducts)

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 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 2024 ²					\$7,060²	\$3,530²				

¹ 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.

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: Entire State
Female Rates
Rates Effective 8/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,516	1,516	2,008	624	1,686	1,178
66	1,516	1,516	2,008	624	1,686	1,178
67	1,516	1,516	2,008	624	1,686	1,178
68	1,531	1,533	2,026	631	1,703	1,221
69	1,564	1,566	2,072	645	1,741	1,271
70	1,603	1,605	2,122	661	1,783	1,317
71	1,653	1,653	2,189	682	1,840	1,364
72	1,704	1,707	2,256	703	1,896	1,411
73	1,761	1,762	2,331	725	1,959	1,458
74	1,820	1,822	2,410	750	2,025	1,506
75	1,887	1,890	2,497	778	2,100	1,557
76	1,953	1,954	2,585	806	2,173	1,606
77	2,019	2,023	2,675	834	2,248	1,660
78	2,088	2,092	2,767	862	2,327	1,716
79	2,157	2,159	2,859	890	2,400	1,772
80	2,226	2,228	2,947	919	2,476	1,832
81	2,294	2,299	3,039	946	2,555	1,889
82	2,368	2,370	3,135	976	2,635	1,948
83	2,440	2,443	3,233	1,005	2,716	2,009
84	2,515	2,518	3,331	1,036	2,798	2,070
85	2,599	2,602	3,441	1,071	2,892	2,140
86	2,674	2,677	3,541	1,101	2,974	2,200
87	2,750	2,753	3,640	1,132	3,060	2,263
88	2,826	2,830	3,742	1,165	3,144	2,327
89	2,905	2,908	3,847	1,196	3,233	2,390
90	2,984	2,989	3,952	1,231	3,320	2,459
91	3,067	3,068	4,061	1,264	3,412	2,525
92	3,149	3,153	4,170	1,299	3,502	2,593
93	3,233	3,237	4,279	1,331	3,597	2,661
94	3,318	3,321	4,392	1,369	3,691	2,731
95	3,406	3,408	4,507	1,404	3,788	2,803
96	3,493	3,497	4,624	1,440	3,886	2,875
97	3,582	3,587	4,743	1,476	3,985	2,947
98	3,673	3,675	4,862	1,513	4,085	3,024
99	3,764	3,767	4,984	1,552	4,188	3,099

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,684	1,685	2,230	696	1,873	1,309
66	1,684	1,685	2,230	696	1,873	1,309
67	1,684	1,685	2,230	696	1,873	1,309
68	1,701	1,702	2,252	702	1,893	1,356
69	1,739	1,740	2,301	717	1,932	1,411
70	1,783	1,783	2,358	734	1,982	1,461
71	1,835	1,838	2,433	758	2,043	1,516
72	1,894	1,897	2,507	781	2,108	1,569
73	1,957	1,959	2,589	807	2,175	1,619
74	2,023	2,023	2,677	834	2,250	1,673
75	2,096	2,098	2,774	865	2,331	1,729
76	2,170	2,172	2,870	895	2,415	1,784
77	2,244	2,249	2,973	926	2,497	1,844
78	2,321	2,324	3,073	958	2,584	1,905
79	2,398	2,401	3,175	989	2,669	1,970
80	2,475	2,476	3,274	1,020	2,752	2,036
81	2,552	2,554	3,378	1,053	2,838	2,099
82	2,629	2,633	3,483	1,084	2,927	2,165
83	2,711	2,715	3,593	1,117	3,016	2,232
84	2,795	2,799	3,702	1,152	3,110	2,300
85	2,889	2,892	3,824	1,191	3,212	2,377
86	2,970	2,975	3,934	1,224	3,307	2,445
87	3,054	3,059	4,045	1,259	3,399	2,515
88	3,141	3,145	4,159	1,294	3,495	2,585
89	3,228	3,231	4,274	1,329	3,593	2,657
90	3,317	3,320	4,391	1,367	3,688	2,730
91	3,409	3,409	4,512	1,404	3,792	2,805
92	3,498	3,502	4,633	1,442	3,892	2,880
93	3,591	3,596	4,755	1,480	3,997	2,957
94	3,688	3,690	4,881	1,519	4,101	3,035
95	3,784	3,788	5,008	1,561	4,210	3,114
96	3,880	3,885	5,140	1,600	4,318	3,194
97	3,980	3,985	5,271	1,640	4,429	3,276
98	4,080	4,084	5,403	1,681	4,539	3,359
99	4,183	4,188	5,537	1,725	4,652	3,443

To calculate a 7% household discount:

Annual premium x modal factor = **modal premium** (round to nearest whole cent)

Modal premium x .93 = **discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual0.5200
 Quarterly0.2650
 Monthly.....0.0833

American Continental Insurance Company
Annual Attained Age Premiums
For Use in ZIP Codes: Entire State
Male Rates
Rates Effective 8/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,741	1,744	2,309	718	1,939	1,355
66	1,741	1,744	2,309	718	1,939	1,355
67	1,741	1,744	2,309	718	1,939	1,355
68	1,761	1,762	2,331	727	1,959	1,403
69	1,800	1,801	2,383	742	2,001	1,460
70	1,843	1,845	2,440	760	2,050	1,514
71	1,901	1,904	2,519	783	2,115	1,570
72	1,962	1,963	2,595	809	2,181	1,623
73	2,025	2,028	2,682	835	2,252	1,676
74	2,094	2,096	2,770	862	2,329	1,733
75	2,170	2,172	2,872	895	2,415	1,791
76	2,246	2,248	2,972	926	2,497	1,847
77	2,322	2,326	3,077	959	2,585	1,907
78	2,404	2,405	3,180	991	2,674	1,972
79	2,482	2,483	3,287	1,024	2,761	2,038
80	2,560	2,564	3,388	1,056	2,849	2,107
81	2,639	2,643	3,496	1,088	2,935	2,171
82	2,722	2,724	3,606	1,122	3,028	2,242
83	2,806	2,809	3,717	1,156	3,121	2,311
84	2,892	2,896	3,831	1,192	3,220	2,380
85	2,990	2,993	3,957	1,232	3,325	2,462
86	3,074	3,078	4,072	1,267	3,422	2,530
87	3,164	3,164	4,186	1,303	3,518	2,603
88	3,250	3,254	4,304	1,341	3,615	2,675
89	3,340	3,344	4,422	1,377	3,717	2,749
90	3,432	3,437	4,545	1,416	3,819	2,825
91	3,527	3,530	4,668	1,453	3,925	2,902
92	3,621	3,626	4,794	1,494	4,028	2,982
93	3,718	3,723	4,921	1,532	4,138	3,060
94	3,815	3,819	5,051	1,574	4,246	3,143
95	3,916	3,919	5,183	1,615	4,356	3,222
96	4,016	4,021	5,319	1,657	4,467	3,307
97	4,119	4,123	5,454	1,698	4,583	3,390
98	4,224	4,229	5,594	1,741	4,698	3,477
99	4,329	4,335	5,731	1,785	4,818	3,563

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,935	1,939	2,563	798	2,154	1,506
66	1,935	1,939	2,563	798	2,154	1,506
67	1,935	1,939	2,563	798	2,154	1,506
68	1,957	1,959	2,589	808	2,176	1,561
69	1,999	2,001	2,648	826	2,222	1,623
70	2,048	2,050	2,714	844	2,279	1,680
71	2,111	2,115	2,798	870	2,351	1,742
72	2,179	2,182	2,883	899	2,426	1,802
73	2,249	2,251	2,977	928	2,503	1,862
74	2,323	2,326	3,078	959	2,586	1,924
75	2,412	2,414	3,192	994	2,681	1,989
76	2,496	2,497	3,302	1,028	2,776	2,052
77	2,582	2,585	3,420	1,064	2,875	2,121
78	2,669	2,673	3,533	1,100	2,972	2,191
79	2,759	2,761	3,652	1,136	3,068	2,264
80	2,845	2,848	3,766	1,172	3,166	2,342
81	2,934	2,937	3,884	1,210	3,264	2,415
82	3,025	3,027	4,007	1,247	3,366	2,490
83	3,117	3,121	4,131	1,285	3,468	2,567
84	3,213	3,219	4,255	1,324	3,576	2,646
85	3,322	3,324	4,398	1,370	3,696	2,735
86	3,417	3,420	4,522	1,409	3,802	2,812
87	3,514	3,517	4,650	1,448	3,909	2,893
88	3,612	3,617	4,782	1,488	4,019	2,972
89	3,711	3,717	4,915	1,529	4,131	3,056
90	3,813	3,818	5,050	1,571	4,242	3,142
91	3,918	3,920	5,190	1,615	4,359	3,225
92	4,024	4,027	5,327	1,660	4,477	3,312
93	4,131	4,137	5,468	1,702	4,597	3,400
94	4,240	4,245	5,613	1,746	4,716	3,491
95	4,352	4,356	5,760	1,794	4,841	3,581
96	4,462	4,466	5,910	1,839	4,965	3,674
97	4,576	4,583	6,060	1,886	5,093	3,768
98	4,693	4,698	6,214	1,933	5,220	3,863
99	4,810	4,817	6,368	1,983	5,353	3,960

To calculate a 7% household discount:

Annual premium x modal factor = **modal premium** (round to nearest whole cent)

Modal premium x .93 = **discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual0.5200
 Quarterly0.2650
 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.

HOUSEHOLD DISCOUNT

In order to be eligible for the Household discount under an American Continental Insurance Company Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently be covered by an American Continental Insurance Company Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (b) someone with whom you are in a civil union partnership; and (c) someone with whom you have continuously resided for the past 12 months. The household discount will only be applicable if a policy for each applicant is issued. The discounted rate will be 7 percent lower than the individual rates and will apply as long as both policies remain in force.

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 \$1,632	\$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
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 \$204 a day	\$0	Up to \$204 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 \$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
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 \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (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 \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (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 \$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
HOSPITALIZATION*			
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
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 \$204 a day	\$0	Up to \$204 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 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
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 \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (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 \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (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 \$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
HOSPITALIZATION*			
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
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 \$204 a day	Up to \$204 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 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
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 \$240 of Medicare-Approved amounts*	\$0	\$240 (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 \$240 of Medicare-Approved amounts*	\$0	\$240 (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 \$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
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 \$2,800 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
HOSPITALIZATION*			
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
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 \$204 a day	Up to \$204 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 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
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 \$240 of Medicare-Approved amounts*	\$0	\$240 (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 \$240 of Medicare-Approved amounts*	\$0	\$240 (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 \$2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2,800 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – 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

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
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 \$1,632	\$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
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 \$204 a day	Up to \$204 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 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
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 \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (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 \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (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 \$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

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 \$1,632	\$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
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 \$204 a day	Up to \$204 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 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
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 \$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.
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD			
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
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 \$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
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