Outline of coverage

Medicare Supplement Insurance

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

Wyoming

Underwritten by

American Continental Insurance Company

An Aetna Company

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ACIMS05031WY

Rates effective: 03/2024 A

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]					**$7,060[2]**	**$3,530[2]**				

[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: All

Female Rates

Rates Effective 3/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,707	2,156	3,081	984	1,883	1,350
66	1,707	2,156	3,081	984	1,883	1,350
67	1,707	2,156	3,081	984	1,883	1,350
68	1,781	2,240	3,211	1,023	1,958	1,406
69	1,859	2,345	3,336	1,066	2,050	1,470
70	1,934	2,438	3,460	1,103	2,130	1,527
71	2,008	2,530	3,578	1,143	2,210	1,589
72	2,076	2,618	3,689	1,179	2,291	1,642
73	2,142	2,703	3,791	1,210	2,362	1,691
74	2,208	2,778	3,887	1,239	2,426	1,740
75	2,263	2,849	3,977	1,268	2,487	1,787
76	2,316	2,914	4,055	1,293	2,548	1,827
77	2,363	2,975	4,127	1,315	2,602	1,867
78	2,406	3,036	4,186	1,337	2,651	1,903
79	2,452	3,085	4,247	1,353	2,696	1,934
80	2,494	3,135	4,298	1,373	2,740	1,967
81	2,527	3,182	4,356	1,390	2,781	1,995
82	2,557	3,223	4,412	1,410	2,821	2,021
83	2,593	3,264	4,465	1,425	2,853	2,048
84	2,623	3,305	4,516	1,442	2,890	2,075
85	2,653	3,350	4,564	1,458	2,926	2,096
86	2,683	3,383	4,610	1,472	2,957	2,120
87	2,710	3,420	4,662	1,486	2,987	2,140
88	2,741	3,452	4,700	1,501	3,019	2,165
89	2,765	3,485	4,740	1,512	3,043	2,187
90	2,793	3,514	4,784	1,525	3,071	2,205
91	2,813	3,543	4,817	1,538	3,103	2,222
92	2,833	3,575	4,849	1,549	3,120	2,241
93	2,856	3,596	4,881	1,557	3,146	2,255
94	2,873	3,622	4,906	1,562	3,164	2,269
95	2,891	3,639	4,929	1,571	3,184	2,281
96	2,907	3,664	4,955	1,583	3,200	2,297
97	2,923	3,683	4,983	1,588	3,222	2,309
98	2,937	3,704	5,004	1,601	3,240	2,321
99	2,960	3,728	5,029	1,604	3,259	2,336

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,896	2,391	3,425	1,091	2,093	1,499
66	1,896	2,391	3,425	1,091	2,093	1,499
67	1,896	2,391	3,425	1,091	2,093	1,499
68	1,980	2,495	3,566	1,136	2,178	1,562
69	2,066	2,605	3,708	1,183	2,277	1,633
70	2,146	2,706	3,843	1,226	2,366	1,699
71	2,231	2,812	3,977	1,268	2,459	1,762
72	2,308	2,908	4,100	1,308	2,543	1,824
73	2,381	3,002	4,209	1,346	2,624	1,881
74	2,452	3,085	4,324	1,377	2,696	1,936
75	2,509	3,165	4,419	1,410	2,765	1,984
76	2,567	3,240	4,500	1,437	2,831	2,029
77	2,630	3,307	4,583	1,461	2,890	2,075
78	2,676	3,367	4,650	1,485	2,944	2,114
79	2,722	3,429	4,716	1,507	2,995	2,149
80	2,765	3,485	4,776	1,524	3,043	2,187
81	2,809	3,534	4,838	1,546	3,087	2,218
82	2,842	3,582	4,897	1,562	3,132	2,246
83	2,881	3,627	4,957	1,583	3,173	2,276
84	2,916	3,676	5,018	1,602	3,211	2,303
85	2,948	3,717	5,072	1,619	3,251	2,330
86	2,982	3,758	5,127	1,636	3,287	2,357
87	3,016	3,798	5,171	1,652	3,323	2,383
88	3,043	3,834	5,224	1,666	3,354	2,405
89	3,073	3,870	5,270	1,685	3,385	2,431
90	3,101	3,907	5,309	1,694	3,416	2,449
91	3,127	3,939	5,349	1,707	3,445	2,471
92	3,152	3,968	5,391	1,721	3,470	2,489
93	3,173	3,997	5,422	1,733	3,492	2,505
94	3,193	4,021	5,451	1,740	3,518	2,522
95	3,213	4,048	5,478	1,749	3,535	2,538
96	3,227	4,071	5,509	1,755	3,556	2,551
97	3,248	4,097	5,533	1,768	3,577	2,565
98	3,265	4,117	5,564	1,777	3,600	2,580
99	3,290	4,145	5,593	1,783	3,621	2,600

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

To calculate the 5% household discount:

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

Modal premium **x** .95 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred 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: All

Male Rates

Rates Effective 3/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,962	2,473	3,545	1,131	2,162	1,552
66	1,962	2,473	3,545	1,131	2,162	1,552
67	1,962	2,473	3,545	1,131	2,162	1,552
68	2,048	2,581	3,689	1,179	2,254	1,617
69	2,141	2,696	3,837	1,225	2,357	1,688
70	2,222	2,801	3,978	1,269	2,450	1,759
71	2,309	2,908	4,116	1,314	2,543	1,824
72	2,390	3,011	4,247	1,353	2,630	1,888
73	2,466	3,103	4,360	1,390	2,712	1,947
74	2,533	3,197	4,470	1,426	2,792	2,004
75	2,598	3,274	4,572	1,458	2,862	2,054
76	2,660	3,352	4,662	1,486	2,930	2,100
77	2,714	3,422	4,740	1,512	2,989	2,146
78	2,769	3,488	4,816	1,538	3,049	2,189
79	2,816	3,551	4,884	1,557	3,104	2,226
80	2,863	3,607	4,946	1,578	3,152	2,263
81	2,904	3,656	5,004	1,601	3,198	2,295
82	2,938	3,708	5,072	1,619	3,240	2,322
83	2,980	3,757	5,133	1,636	3,283	2,355
84	3,018	3,801	5,190	1,660	3,324	2,383
85	3,051	3,846	5,250	1,674	3,362	2,411
86	3,085	3,891	5,305	1,691	3,400	2,438
87	3,119	3,933	5,356	1,711	3,436	2,463
88	3,152	3,970	5,408	1,726	3,472	2,491
89	3,182	4,010	5,453	1,740	3,506	2,516
90	3,211	4,045	5,494	1,752	3,533	2,534
91	3,237	4,079	5,535	1,768	3,563	2,557
92	3,261	4,109	5,576	1,780	3,587	2,575
93	3,285	4,139	5,612	1,790	3,616	2,594
94	3,304	4,163	5,645	1,800	3,638	2,610
95	3,323	4,189	5,669	1,811	3,661	2,625
96	3,341	4,210	5,700	1,817	3,680	2,641
97	3,363	4,236	5,727	1,829	3,704	2,658
98	3,383	4,260	5,757	1,839	3,724	2,672
99	3,402	4,286	5,789	1,846	3,746	2,689

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	2,183	2,750	3,937	1,258	2,404	1,724
66	2,183	2,750	3,937	1,258	2,404	1,724
67	2,183	2,750	3,937	1,258	2,404	1,724
68	2,274	2,867	4,103	1,308	2,507	1,797
69	2,376	2,993	4,263	1,361	2,617	1,877
70	2,471	3,113	4,419	1,410	2,722	1,953
71	2,564	3,232	4,572	1,458	2,825	2,028
72	2,653	3,350	4,716	1,507	2,923	2,096
73	2,741	3,448	4,843	1,547	3,018	2,162
74	2,816	3,551	4,966	1,585	3,104	2,226
75	2,888	3,639	5,082	1,620	3,178	2,280
76	2,957	3,722	5,179	1,655	3,254	2,334
77	3,019	3,803	5,270	1,685	3,324	2,383
78	3,074	3,875	5,349	1,705	3,386	2,433
79	3,131	3,944	5,423	1,733	3,447	2,472
80	3,182	4,008	5,490	1,752	3,504	2,515
81	3,226	4,065	5,566	1,777	3,553	2,548
82	3,268	4,118	5,632	1,800	3,604	2,581
83	3,312	4,172	5,702	1,822	3,648	2,615
84	3,353	4,223	5,770	1,841	3,694	2,650
85	3,396	4,274	5,833	1,861	3,735	2,678
86	3,429	4,325	5,894	1,882	3,778	2,710
87	3,465	4,368	5,948	1,896	3,819	2,737
88	3,502	4,410	6,008	1,915	3,854	2,768
89	3,534	4,453	6,061	1,934	3,893	2,790
90	3,565	4,489	6,111	1,949	3,928	2,815
91	3,594	4,532	6,152	1,961	3,958	2,843
92	3,623	4,566	6,194	1,977	3,991	2,862
93	3,650	4,596	6,231	1,989	4,018	2,885
94	3,675	4,624	6,269	2,002	4,044	2,900
95	3,693	4,656	6,297	2,012	4,068	2,914
96	3,716	4,681	6,332	2,020	4,094	2,935
97	3,737	4,709	6,363	2,030	4,116	2,950
98	3,758	4,735	6,397	2,044	4,138	2,969
99	3,783	4,763	6,431	2,050	4,163	2,986

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

To calculate the 5% household discount:

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

Modal premium **x** .95 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred 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 annual 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) be someone with whom you are in a civil union partnership; and (c) be 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 5 percent lower than the individual rates.

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 40512-9701. 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 test, 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 – TEST 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 test, 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 – TEST 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 test, 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 – TEST 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 test, 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 – TEST 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 test, 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 – TEST 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 test, 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 – TEST 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