



Outline of coverage

Medicare Supplement Insurance

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

South Dakota

Underwritten by
**American Continental
Insurance Company**

An Aetna Company

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

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

This chart shows the benefits included in each of the standard Medicare supplement plans. 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 2025 ²					\$7,220 ²	\$3,610 ²				

¹ Plans F and G also have a high deductible option, which require first paying a plan deductible of **\$2,870** 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 6/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,520	2,974	4,114	883	2,218	2,009
65	1,902	2,247	3,190	686	1,677	1,518
66	1,902	2,247	3,190	686	1,677	1,518
67	1,902	2,247	3,190	686	1,677	1,518
68	1,986	2,340	3,320	714	1,746	1,580
69	2,074	2,446	3,449	742	1,826	1,651
70	2,155	2,546	3,577	769	1,898	1,719
71	2,238	2,641	3,703	795	1,969	1,783
72	2,317	2,731	3,818	820	2,036	1,846
73	2,389	2,818	3,922	843	2,102	1,903
74	2,461	2,899	4,022	864	2,162	1,958
75	2,520	2,974	4,114	883	2,218	2,009
76	2,580	3,042	4,194	902	2,268	2,054
77	2,634	3,104	4,267	916	2,317	2,100
78	2,684	3,166	4,330	931	2,362	2,140
79	2,733	3,221	4,393	944	2,403	2,176
80	2,778	3,272	4,449	957	2,442	2,213
81	2,817	3,318	4,506	969	2,476	2,242
82	2,853	3,362	4,566	981	2,510	2,274
83	2,894	3,407	4,615	994	2,542	2,303
84	2,926	3,449	4,670	1,004	2,575	2,334
85	2,957	3,491	4,723	1,015	2,604	2,358
86	2,995	3,530	4,772	1,026	2,634	2,384
87	3,024	3,567	4,818	1,036	2,660	2,410
88	3,055	3,603	4,865	1,046	2,686	2,438
89	3,083	3,637	4,902	1,054	2,713	2,458
90	3,111	3,668	4,948	1,063	2,738	2,479
91	3,135	3,700	4,986	1,071	2,761	2,499
92	3,159	3,726	5,015	1,078	2,782	2,519
93	3,183	3,754	5,050	1,086	2,800	2,536
94	3,206	3,778	5,075	1,090	2,819	2,551
95	3,224	3,799	5,101	1,095	2,834	2,567
96	3,239	3,824	5,130	1,103	2,851	2,584
97	3,261	3,842	5,155	1,108	2,868	2,598
98	3,278	3,866	5,184	1,114	2,886	2,612
99	3,301	3,890	5,202	1,118	2,902	2,628

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,799	3,302	4,571	982	2,464	2,230
65	2,118	2,498	3,542	762	1,862	1,686
66	2,118	2,498	3,542	762	1,862	1,686
67	2,118	2,498	3,542	762	1,862	1,686
68	2,206	2,602	3,690	794	1,941	1,759
69	2,303	2,718	3,836	824	2,028	1,838
70	2,394	2,825	3,977	854	2,108	1,910
71	2,488	2,933	4,114	883	2,188	1,979
72	2,574	3,036	4,241	912	2,265	2,051
73	2,656	3,131	4,357	938	2,334	2,116
74	2,733	3,221	4,470	960	2,403	2,177
75	2,799	3,302	4,571	982	2,464	2,230
76	2,864	3,379	4,657	1,000	2,520	2,281
77	2,927	3,451	4,740	1,019	2,576	2,334
78	2,983	3,516	4,810	1,035	2,623	2,376
79	3,035	3,578	4,881	1,047	2,670	2,416
80	3,083	3,637	4,938	1,062	2,713	2,458
81	3,128	3,689	5,008	1,075	2,750	2,494
82	3,169	3,738	5,070	1,090	2,788	2,526
83	3,210	3,789	5,130	1,103	2,825	2,559
84	3,252	3,833	5,190	1,115	2,860	2,590
85	3,288	3,878	5,248	1,127	2,894	2,619
86	3,329	3,923	5,303	1,140	2,926	2,650
87	3,362	3,962	5,355	1,151	2,957	2,678
88	3,394	4,002	5,403	1,161	2,988	2,704
89	3,429	4,039	5,451	1,172	3,014	2,732
90	3,458	4,076	5,490	1,181	3,041	2,754
91	3,486	4,109	5,536	1,190	3,066	2,777
92	3,513	4,143	5,574	1,199	3,088	2,800
93	3,536	4,172	5,606	1,205	3,112	2,818
94	3,559	4,198	5,640	1,212	3,130	2,838
95	3,582	4,222	5,668	1,218	3,149	2,855
96	3,601	4,247	5,695	1,223	3,168	2,868
97	3,623	4,273	5,724	1,230	3,186	2,886
98	3,642	4,297	5,757	1,238	3,204	2,903
99	3,669	4,323	5,786	1,243	3,225	2,922

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

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

Modal factors

Semi-annual0.5200
Quarterly0.2650
Monthly0.0833

American Continental Insurance Company

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

Rates Effective 6/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,898	3,417	4,730	1,016	2,549	2,310
65	2,190	2,582	3,667	788	1,926	1,745
66	2,190	2,582	3,667	788	1,926	1,745
67	2,190	2,582	3,667	788	1,926	1,745
68	2,282	2,691	3,818	820	2,007	1,818
69	2,386	2,814	3,970	853	2,099	1,900
70	2,479	2,924	4,115	884	2,180	1,976
71	2,575	3,036	4,259	914	2,265	2,051
72	2,665	3,142	4,393	944	2,342	2,123
73	2,750	3,238	4,508	969	2,417	2,190
74	2,826	3,334	4,630	995	2,488	2,251
75	2,898	3,417	4,730	1,016	2,549	2,310
76	2,966	3,497	4,818	1,036	2,610	2,362
77	3,025	3,571	4,902	1,054	2,664	2,414
78	3,088	3,640	4,983	1,071	2,715	2,461
79	3,140	3,702	5,052	1,086	2,762	2,502
80	3,194	3,765	5,115	1,098	2,808	2,544
81	3,236	3,815	5,184	1,114	2,848	2,578
82	3,281	3,870	5,248	1,127	2,887	2,613
83	3,325	3,919	5,311	1,141	2,924	2,646
84	3,364	3,966	5,369	1,154	2,961	2,680
85	3,405	4,011	5,431	1,166	2,995	2,713
86	3,442	4,058	5,486	1,180	3,026	2,742
87	3,479	4,103	5,543	1,191	3,060	2,770
88	3,514	4,144	5,594	1,202	3,090	2,801
89	3,546	4,184	5,641	1,212	3,119	2,827
90	3,581	4,219	5,685	1,222	3,147	2,850
91	3,607	4,254	5,726	1,230	3,172	2,874
92	3,634	4,286	5,767	1,240	3,199	2,895
93	3,661	4,319	5,803	1,248	3,220	2,918
94	3,684	4,346	5,838	1,254	3,242	2,936
95	3,703	4,371	5,866	1,262	3,261	2,953
96	3,729	4,395	5,895	1,267	3,278	2,968
97	3,750	4,418	5,925	1,274	3,296	2,988
98	3,771	4,446	5,957	1,280	3,316	3,006
99	3,794	4,473	5,986	1,286	3,336	3,023

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,221	3,797	5,257	1,130	2,832	2,566
65	2,434	2,870	4,074	876	2,141	1,939
66	2,434	2,870	4,074	876	2,141	1,939
67	2,434	2,870	4,074	876	2,141	1,939
68	2,535	2,990	4,245	912	2,230	2,019
69	2,647	3,126	4,408	947	2,332	2,111
70	2,755	3,249	4,571	982	2,425	2,198
71	2,862	3,372	4,730	1,016	2,516	2,279
72	2,957	3,491	4,881	1,047	2,604	2,358
73	3,053	3,599	5,010	1,076	2,685	2,432
74	3,140	3,702	5,139	1,105	2,762	2,502
75	3,221	3,797	5,257	1,130	2,832	2,566
76	3,295	3,882	5,356	1,152	2,897	2,626
77	3,366	3,970	5,451	1,172	2,961	2,680
78	3,430	4,042	5,534	1,189	3,018	2,734
79	3,489	4,118	5,611	1,205	3,070	2,778
80	3,546	4,181	5,683	1,222	3,118	2,826
81	3,595	4,241	5,758	1,238	3,165	2,866
82	3,642	4,298	5,828	1,253	3,207	2,905
83	3,694	4,353	5,903	1,268	3,248	2,942
84	3,740	4,408	5,971	1,283	3,289	2,978
85	3,782	4,460	6,034	1,297	3,327	3,013
86	3,824	4,513	6,100	1,310	3,365	3,046
87	3,864	4,557	6,154	1,323	3,400	3,080
88	3,905	4,604	6,212	1,335	3,435	3,112
89	3,942	4,646	6,270	1,347	3,466	3,139
90	3,974	4,688	6,319	1,358	3,498	3,167
91	4,011	4,727	6,366	1,367	3,526	3,197
92	4,040	4,764	6,408	1,378	3,554	3,219
93	4,068	4,795	6,446	1,386	3,578	3,242
94	4,094	4,826	6,484	1,394	3,602	3,261
95	4,118	4,856	6,517	1,401	3,622	3,279
96	4,144	4,885	6,552	1,407	3,644	3,298
97	4,165	4,914	6,586	1,414	3,664	3,319
98	4,193	4,943	6,620	1,423	3,686	3,338
99	4,215	4,970	6,651	1,430	3,709	3,360

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

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

Modal factors

Semi-annual0.5200
Quarterly0.2650
Monthly0.0833

PREMIUM INFORMATION

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

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

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

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$0	\$1,676 (Part A Deductible)
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$838 a day	\$838 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 \$209.50 a day	\$0	Up to \$209.50 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 \$257 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 \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (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 \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (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 \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (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 \$1,676	\$1,676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$838 a day	\$838 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 \$209.50 a day	\$0	Up to \$209.50 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 B

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

*Once you have been billed \$257 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 \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (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 \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (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 \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (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 \$1,676	\$1,676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$838 a day	\$838 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 \$209.50 a day	Up to \$209.50 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 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 \$257 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 \$257 of Medicare-Approved amounts*	\$0	\$257 (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 \$257 of Medicare-Approved amounts*	\$0	\$257 (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 \$257 of Medicare-Approved amounts*	\$0	\$257 (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 \$2,870 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$2,870. 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 \$2,870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2,870 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$1,676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$838 a day	\$838 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 \$209.50 a day	Up to \$209.50 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 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 \$257 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 \$2,870 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are \$2,870. 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 \$2,870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2,870 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 \$257 of Medicare-Approved amounts*	\$0	\$257 (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 \$257 of Medicare-Approved amounts*	\$0	\$257 (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 \$2,870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2,870 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$257 of Medicare-Approved amounts*	\$0	\$257 (Part B Deductible)	\$0
Remainder of Medicare-Approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2,870 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 \$1,676	\$1,676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$838 a day	\$838 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 \$209.50 a day	Up to \$209.50 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 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 \$257 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 \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (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 \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (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 \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (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 \$1,676	\$1,676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$838 a day	\$838 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 \$209.50 a day	Up to \$209.50 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 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 \$257 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 \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (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 \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (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 \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (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