



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.AetnaSeniorProducts.com)

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

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

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

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G 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 8/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,516	1,516	2,410	624	2,023	1,414
66	1,516	1,516	2,410	624	2,023	1,414
67	1,516	1,516	2,410	624	2,023	1,414
68	1,531	1,533	2,431	631	2,044	1,465
69	1,564	1,566	2,486	645	2,089	1,525
70	1,603	1,605	2,546	661	2,140	1,580
71	1,653	1,653	2,627	682	2,208	1,637
72	1,704	1,707	2,707	703	2,275	1,693
73	1,761	1,762	2,797	725	2,351	1,750
74	1,820	1,822	2,892	750	2,430	1,807
75	1,887	1,890	2,996	778	2,520	1,868
76	1,953	1,954	3,102	806	2,608	1,927
77	2,019	2,023	3,210	834	2,698	1,992
78	2,088	2,092	3,320	862	2,792	2,059
79	2,157	2,159	3,431	890	2,880	2,126
80	2,226	2,228	3,536	919	2,971	2,198
81	2,294	2,299	3,647	946	3,066	2,267
82	2,368	2,370	3,762	976	3,162	2,338
83	2,440	2,443	3,880	1,005	3,259	2,411
84	2,515	2,518	3,997	1,036	3,358	2,484
85	2,599	2,602	4,129	1,071	3,470	2,568
86	2,674	2,677	4,249	1,101	3,569	2,640
87	2,750	2,753	4,368	1,132	3,672	2,716
88	2,826	2,830	4,490	1,165	3,773	2,792
89	2,905	2,908	4,616	1,196	3,880	2,868
90	2,984	2,989	4,742	1,231	3,984	2,951
91	3,067	3,068	4,873	1,264	4,094	3,030
92	3,149	3,153	5,004	1,299	4,202	3,112
93	3,233	3,237	5,135	1,331	4,316	3,193
94	3,318	3,321	5,270	1,369	4,429	3,277
95	3,406	3,408	5,408	1,404	4,546	3,364
96	3,493	3,497	5,549	1,440	4,663	3,450
97	3,582	3,587	5,692	1,476	4,782	3,536
98	3,673	3,675	5,834	1,513	4,902	3,629
99	3,764	3,767	5,981	1,552	5,026	3,719

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,684	1,685	2,676	696	2,248	1,571
66	1,684	1,685	2,676	696	2,248	1,571
67	1,684	1,685	2,676	696	2,248	1,571
68	1,701	1,702	2,702	702	2,272	1,627
69	1,739	1,740	2,761	717	2,318	1,693
70	1,783	1,783	2,830	734	2,378	1,753
71	1,835	1,838	2,920	758	2,452	1,819
72	1,894	1,897	3,008	781	2,530	1,883
73	1,957	1,959	3,107	807	2,610	1,943
74	2,023	2,023	3,212	834	2,700	2,008
75	2,096	2,098	3,329	865	2,797	2,075
76	2,170	2,172	3,444	895	2,898	2,141
77	2,244	2,249	3,568	926	2,996	2,213
78	2,321	2,324	3,688	958	3,101	2,286
79	2,398	2,401	3,810	989	3,203	2,364
80	2,475	2,476	3,929	1,020	3,302	2,443
81	2,552	2,554	4,054	1,053	3,406	2,519
82	2,629	2,633	4,180	1,084	3,512	2,598
83	2,711	2,715	4,312	1,117	3,619	2,678
84	2,795	2,799	4,442	1,152	3,732	2,760
85	2,889	2,892	4,589	1,191	3,854	2,852
86	2,970	2,975	4,721	1,224	3,968	2,934
87	3,054	3,059	4,854	1,259	4,079	3,018
88	3,141	3,145	4,991	1,294	4,194	3,102
89	3,228	3,231	5,129	1,329	4,312	3,188
90	3,317	3,320	5,269	1,367	4,426	3,276
91	3,409	3,409	5,414	1,404	4,550	3,366
92	3,498	3,502	5,560	1,442	4,670	3,456
93	3,591	3,596	5,706	1,480	4,796	3,548
94	3,688	3,690	5,857	1,519	4,921	3,642
95	3,784	3,788	6,010	1,561	5,052	3,737
96	3,880	3,885	6,168	1,600	5,182	3,833
97	3,980	3,985	6,325	1,640	5,315	3,931
98	4,080	4,084	6,484	1,681	5,447	4,031
99	4,183	4,188	6,644	1,725	5,582	4,132

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 8/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,741	1,744	2,771	718	2,327	1,626
66	1,741	1,744	2,771	718	2,327	1,626
67	1,741	1,744	2,771	718	2,327	1,626
68	1,761	1,762	2,797	727	2,351	1,684
69	1,800	1,801	2,860	742	2,401	1,752
70	1,843	1,845	2,928	760	2,460	1,817
71	1,901	1,904	3,023	783	2,538	1,884
72	1,962	1,963	3,114	809	2,617	1,948
73	2,025	2,028	3,218	835	2,702	2,011
74	2,094	2,096	3,324	862	2,795	2,080
75	2,170	2,172	3,446	895	2,898	2,149
76	2,246	2,248	3,566	926	2,996	2,216
77	2,322	2,326	3,692	959	3,102	2,288
78	2,404	2,405	3,816	991	3,209	2,366
79	2,482	2,483	3,944	1,024	3,313	2,446
80	2,560	2,564	4,066	1,056	3,419	2,528
81	2,639	2,643	4,195	1,088	3,522	2,605
82	2,722	2,724	4,327	1,122	3,634	2,690
83	2,806	2,809	4,460	1,156	3,745	2,773
84	2,892	2,896	4,597	1,192	3,864	2,856
85	2,990	2,993	4,748	1,232	3,990	2,954
86	3,074	3,078	4,886	1,267	4,106	3,036
87	3,164	3,164	5,023	1,303	4,222	3,124
88	3,250	3,254	5,165	1,341	4,338	3,210
89	3,340	3,344	5,306	1,377	4,460	3,299
90	3,432	3,437	5,454	1,416	4,583	3,390
91	3,527	3,530	5,602	1,453	4,710	3,482
92	3,621	3,626	5,753	1,494	4,834	3,578
93	3,718	3,723	5,905	1,532	4,966	3,672
94	3,815	3,819	6,061	1,574	5,095	3,772
95	3,916	3,919	6,220	1,615	5,227	3,866
96	4,016	4,021	6,383	1,657	5,360	3,968
97	4,119	4,123	6,545	1,698	5,500	4,068
98	4,224	4,229	6,713	1,741	5,638	4,172
99	4,329	4,335	6,877	1,785	5,782	4,276

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,935	1,939	3,076	798	2,585	1,807
66	1,935	1,939	3,076	798	2,585	1,807
67	1,935	1,939	3,076	798	2,585	1,807
68	1,957	1,959	3,107	808	2,611	1,873
69	1,999	2,001	3,178	826	2,666	1,948
70	2,048	2,050	3,257	844	2,735	2,016
71	2,111	2,115	3,358	870	2,821	2,090
72	2,179	2,182	3,460	899	2,911	2,162
73	2,249	2,251	3,572	928	3,004	2,234
74	2,323	2,326	3,694	959	3,103	2,309
75	2,412	2,414	3,830	994	3,217	2,387
76	2,496	2,497	3,962	1,028	3,331	2,462
77	2,582	2,585	4,104	1,064	3,450	2,545
78	2,669	2,673	4,240	1,100	3,566	2,629
79	2,759	2,761	4,382	1,136	3,682	2,717
80	2,845	2,848	4,519	1,172	3,799	2,810
81	2,934	2,937	4,661	1,210	3,917	2,898
82	3,025	3,027	4,808	1,247	4,039	2,988
83	3,117	3,121	4,957	1,285	4,162	3,080
84	3,213	3,219	5,106	1,324	4,291	3,175
85	3,322	3,324	5,278	1,370	4,435	3,282
86	3,417	3,420	5,426	1,409	4,562	3,374
87	3,514	3,517	5,580	1,448	4,691	3,472
88	3,612	3,617	5,738	1,488	4,823	3,566
89	3,711	3,717	5,898	1,529	4,957	3,667
90	3,813	3,818	6,060	1,571	5,090	3,770
91	3,918	3,920	6,228	1,615	5,231	3,870
92	4,024	4,027	6,392	1,660	5,372	3,974
93	4,131	4,137	6,562	1,702	5,516	4,080
94	4,240	4,245	6,736	1,746	5,659	4,189
95	4,352	4,356	6,912	1,794	5,809	4,297
96	4,462	4,466	7,092	1,839	5,958	4,409
97	4,576	4,583	7,272	1,886	6,112	4,522
98	4,693	4,698	7,457	1,933	6,264	4,636
99	4,810	4,817	7,642	1,983	6,424	4,752

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 \$1,676	\$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