



Outline of coverage

Medicare Supplement Insurance

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

North 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. 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 6/1/2024

ATTAINED AGE	NON-TOBACCO					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,784	2,248	3,250	872	1,777	1,295
66	1,784	2,248	3,250	872	1,777	1,295
67	1,784	2,248	3,250	872	1,777	1,295
68	1,859	2,342	3,384	909	1,850	1,350
69	1,941	2,449	3,514	944	1,932	1,410
70	2,019	2,547	3,643	978	2,009	1,466
71	2,096	2,641	3,769	1,013	2,087	1,522
72	2,170	2,733	3,891	1,045	2,162	1,575
73	2,238	2,819	3,995	1,072	2,230	1,625
74	2,305	2,901	4,098	1,100	2,292	1,671
75	2,360	2,976	4,191	1,125	2,351	1,715
76	2,415	3,041	4,271	1,149	2,405	1,754
77	2,466	3,107	4,347	1,165	2,456	1,794
78	2,511	3,165	4,413	1,186	2,503	1,827
79	2,560	3,224	4,476	1,201	2,547	1,857
80	2,602	3,274	4,531	1,216	2,588	1,888
81	2,637	3,318	4,590	1,233	2,627	1,915
82	2,672	3,365	4,649	1,250	2,659	1,941
83	2,710	3,409	4,703	1,264	2,693	1,965
84	2,738	3,450	4,759	1,279	2,727	1,991
85	2,769	3,494	4,812	1,293	2,760	2,014
86	2,803	3,532	4,861	1,306	2,791	2,035
87	2,832	3,569	4,911	1,318	2,818	2,057
88	2,862	3,606	4,952	1,332	2,850	2,079
89	2,887	3,641	4,995	1,341	2,876	2,099
90	2,911	3,672	5,040	1,353	2,900	2,118
91	2,938	3,701	5,078	1,363	2,926	2,134
92	2,960	3,731	5,110	1,372	2,947	2,148
93	2,979	3,755	5,141	1,382	2,969	2,165
94	3,003	3,780	5,168	1,387	2,988	2,179
95	3,018	3,799	5,197	1,395	3,006	2,192
96	3,036	3,825	5,222	1,403	3,021	2,206
97	3,054	3,848	5,252	1,412	3,039	2,217
98	3,070	3,868	5,278	1,416	3,057	2,230
99	3,090	3,891	5,304	1,425	3,078	2,244

ATTAINED AGE	TOBACCO					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,981	2,498	3,611	969	1,972	1,440
66	1,981	2,498	3,611	969	1,972	1,440
67	1,981	2,498	3,611	969	1,972	1,440
68	2,066	2,603	3,758	1,010	2,056	1,501
69	2,158	2,717	3,910	1,051	2,151	1,568
70	2,242	2,827	4,049	1,085	2,235	1,629
71	2,326	2,938	4,191	1,125	2,319	1,691
72	2,411	3,037	4,320	1,159	2,400	1,750
73	2,485	3,131	4,440	1,192	2,475	1,805
74	2,560	3,224	4,553	1,224	2,547	1,859
75	2,620	3,303	4,659	1,251	2,610	1,905
76	2,683	3,380	4,743	1,273	2,669	1,948
77	2,742	3,451	4,828	1,296	2,729	1,991
78	2,792	3,521	4,905	1,318	2,781	2,029
79	2,842	3,581	4,971	1,334	2,830	2,063
80	2,887	3,641	5,035	1,352	2,876	2,099
81	2,927	3,689	5,097	1,370	2,917	2,129
82	2,968	3,742	5,165	1,387	2,957	2,157
83	3,006	3,790	5,226	1,403	2,995	2,184
84	3,045	3,836	5,289	1,417	3,033	2,211
85	3,078	3,880	5,347	1,435	3,068	2,236
86	3,114	3,924	5,402	1,451	3,101	2,264
87	3,148	3,964	5,454	1,464	3,133	2,287
88	3,177	4,005	5,505	1,478	3,166	2,308
89	3,209	4,043	5,551	1,493	3,194	2,331
90	3,241	4,077	5,598	1,504	3,223	2,353
91	3,264	4,111	5,641	1,515	3,250	2,369
92	3,287	4,144	5,681	1,527	3,274	2,389
93	3,312	4,172	5,715	1,534	3,297	2,405
94	3,335	4,198	5,745	1,544	3,318	2,423
95	3,354	4,226	5,775	1,550	3,337	2,437
96	3,370	4,250	5,804	1,558	3,358	2,449
97	3,393	4,276	5,834	1,567	3,377	2,463
98	3,412	4,299	5,866	1,575	3,397	2,478
99	3,433	4,326	5,896	1,583	3,418	2,494

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

If applying during Open Enrollment or Guaranteed Issue Period, use Non-Tobacco 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	NON-TOBACCO					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	2,052	2,583	3,737	1,003	2,042	1,491
66	2,052	2,583	3,737	1,003	2,042	1,491
67	2,052	2,583	3,737	1,003	2,042	1,491
68	2,136	2,695	3,891	1,045	2,128	1,552
69	2,231	2,815	4,040	1,085	2,224	1,624
70	2,322	2,926	4,193	1,126	2,313	1,687
71	2,413	3,037	4,338	1,165	2,400	1,750
72	2,496	3,143	4,476	1,201	2,483	1,811
73	2,572	3,243	4,593	1,233	2,561	1,870
74	2,647	3,337	4,716	1,267	2,638	1,923
75	2,714	3,419	4,820	1,295	2,703	1,973
76	2,776	3,498	4,911	1,318	2,763	2,016
77	2,835	3,572	4,995	1,341	2,826	2,060
78	2,893	3,642	5,076	1,363	2,879	2,100
79	2,941	3,704	5,148	1,382	2,927	2,137
80	2,990	3,766	5,211	1,400	2,975	2,172
81	3,030	3,822	5,278	1,416	3,018	2,202
82	3,071	3,871	5,347	1,435	3,059	2,231
83	3,113	3,924	5,410	1,452	3,097	2,258
84	3,148	3,966	5,473	1,470	3,136	2,287
85	3,189	4,016	5,534	1,487	3,172	2,315
86	3,224	4,060	5,590	1,500	3,210	2,341
87	3,256	4,106	5,647	1,517	3,244	2,366
88	3,290	4,145	5,697	1,532	3,276	2,390
89	3,318	4,185	5,753	1,544	3,307	2,413
90	3,352	4,223	5,796	1,555	3,336	2,433
91	3,380	4,256	5,836	1,567	3,364	2,454
92	3,402	4,289	5,876	1,577	3,390	2,472
93	3,428	4,321	5,916	1,590	3,411	2,491
94	3,449	4,349	5,947	1,599	3,436	2,505
95	3,468	4,371	5,980	1,604	3,456	2,521
96	3,491	4,396	6,006	1,613	3,476	2,535
97	3,511	4,421	6,036	1,622	3,494	2,550
98	3,532	4,449	6,069	1,629	3,515	2,566
99	3,553	4,475	6,099	1,635	3,537	2,581

ATTAINED AGE	TOBACCO					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	2,281	2,871	4,151	1,114	2,268	1,657
66	2,281	2,871	4,151	1,114	2,268	1,657
67	2,281	2,871	4,151	1,114	2,268	1,657
68	2,376	2,993	4,321	1,159	2,365	1,726
69	2,479	3,125	4,492	1,207	2,470	1,803
70	2,581	3,250	4,659	1,251	2,568	1,875
71	2,679	3,375	4,820	1,295	2,667	1,945
72	2,769	3,494	4,971	1,334	2,760	2,014
73	2,860	3,603	5,104	1,371	2,846	2,076
74	2,941	3,704	5,237	1,406	2,927	2,137
75	3,016	3,798	5,353	1,439	3,001	2,191
76	3,087	3,888	5,454	1,466	3,071	2,242
77	3,149	3,975	5,551	1,493	3,136	2,287
78	3,210	4,045	5,640	1,513	3,197	2,333
79	3,267	4,117	5,716	1,534	3,252	2,374
80	3,318	4,183	5,789	1,555	3,307	2,412
81	3,369	4,244	5,867	1,575	3,356	2,447
82	3,414	4,300	5,939	1,598	3,399	2,479
83	3,460	4,355	6,011	1,616	3,442	2,512
84	3,499	4,409	6,082	1,632	3,486	2,544
85	3,542	4,462	6,149	1,652	3,527	2,571
86	3,581	4,515	6,214	1,669	3,566	2,601
87	3,618	4,559	6,272	1,684	3,604	2,628
88	3,656	4,604	6,332	1,699	3,641	2,656
89	3,689	4,647	6,389	1,715	3,674	2,680
90	3,719	4,689	6,437	1,729	3,709	2,706
91	3,754	4,730	6,488	1,742	3,736	2,728
92	3,783	4,767	6,532	1,753	3,766	2,749
93	3,808	4,797	6,571	1,764	3,792	2,767
94	3,834	4,827	6,608	1,775	3,817	2,784
95	3,856	4,859	6,642	1,784	3,839	2,799
96	3,879	4,888	6,677	1,791	3,860	2,817
97	3,902	4,916	6,706	1,802	3,885	2,834
98	3,924	4,944	6,743	1,812	3,909	2,851
99	3,946	4,973	6,775	1,818	3,930	2,868

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

If applying during Open Enrollment or Guaranteed Issue Period, use Non-Tobacco 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