Outline of coverage

Medicare Supplement Insurance

Benefit plans: A, B, F, HF, G, N

West Virginia

Underwritten by

American Continental Insurance Company

An Aetna Company

aetnaseniorproducts.com

ACIMS05032WV

Rates effective: 08/2019 A

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.
Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50 %	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2019[2]					$5,560 *2	$2,780 *2				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,300 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 of State

Female Rates

Rates Effective 8/1/2019

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,140	1,227	1,550	505	1,228	992
66	1,140	1,227	1,550	505	1,228	992
67	1,140	1,227	1,550	505	1,228	992
68	1,152	1,240	1,565	511	1,241	1,028
69	1,177	1,267	1,600	522	1,268	1,069
70	1,206	1,298	1,639	535	1,299	1,108
71	1,244	1,338	1,691	551	1,341	1,148
72	1,283	1,381	1,743	569	1,382	1,188
73	1,325	1,426	1,800	587	1,427	1,227
74	1,370	1,474	1,861	606	1,475	1,268
75	1,420	1,528	1,929	629	1,529	1,310
76	1,470	1,581	1,996	651	1,583	1,352
77	1,520	1,637	2,066	674	1,638	1,397
78	1,572	1,692	2,136	697	1,694	1,444
79	1,624	1,747	2,207	720	1,749	1,492
80	1,675	1,802	2,276	743	1,804	1,542
81	1,727	1,860	2,347	765	1,861	1,590
82	1,782	1,917	2,421	789	1,919	1,640
83	1,837	1,976	2,496	813	1,978	1,691
84	1,893	2,037	2,572	838	2,039	1,743
85	1,956	2,105	2,657	866	2,107	1,801
86	2,012	2,165	2,734	891	2,167	1,852
87	2,070	2,227	2,811	916	2,229	1,905
88	2,127	2,289	2,890	942	2,291	1,958
89	2,186	2,352	2,970	968	2,355	2,012
90	2,246	2,417	3,052	995	2,419	2,069
91	2,308	2,482	3,136	1,022	2,486	2,125
92	2,370	2,550	3,220	1,050	2,552	2,182
93	2,433	2,618	3,305	1,077	2,621	2,240
94	2,497	2,686	3,392	1,107	2,689	2,299
95	2,563	2,757	3,481	1,136	2,760	2,359
96	2,628	2,828	3,571	1,165	2,831	2,420
97	2,696	2,901	3,663	1,194	2,904	2,481
98	2,764	2,973	3,755	1,224	2,976	2,545
99	2,833	3,048	3,849	1,255	3,051	2,608

Modal Factors: Semi-Annual: 0.5200

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,267	1,363	1,722	562	1,364	1,102
66	1,267	1,363	1,722	562	1,364	1,102
67	1,267	1,363	1,722	562	1,364	1,102
68	1,280	1,377	1,739	568	1,379	1,142
69	1,308	1,407	1,777	580	1,408	1,188
70	1,341	1,442	1,821	594	1,444	1,230
71	1,382	1,487	1,879	613	1,489	1,276
72	1,426	1,535	1,936	632	1,536	1,320
73	1,473	1,584	2,000	652	1,585	1,363
74	1,522	1,637	2,068	674	1,639	1,408
75	1,578	1,697	2,143	699	1,698	1,456
76	1,633	1,757	2,217	724	1,759	1,502
77	1,689	1,819	2,296	749	1,820	1,552
78	1,747	1,880	2,373	774	1,882	1,604
79	1,805	1,942	2,452	800	1,944	1,658
80	1,862	2,003	2,528	825	2,005	1,714
81	1,920	2,066	2,608	851	2,068	1,767
82	1,979	2,130	2,690	877	2,132	1,822
83	2,040	2,195	2,774	904	2,198	1,879
84	2,103	2,264	2,858	932	2,266	1,936
85	2,174	2,339	2,953	963	2,341	2,001
86	2,236	2,406	3,038	990	2,409	2,058
87	2,299	2,474	3,123	1,018	2,476	2,117
88	2,363	2,544	3,212	1,047	2,546	2,176
89	2,429	2,614	3,300	1,075	2,617	2,236
90	2,496	2,685	3,391	1,106	2,687	2,298
91	2,565	2,758	3,484	1,136	2,762	2,361
92	2,633	2,833	3,578	1,167	2,836	2,424
93	2,703	2,909	3,672	1,197	2,912	2,489
94	2,775	2,985	3,769	1,229	2,988	2,555
95	2,848	3,064	3,868	1,262	3,067	2,621
96	2,920	3,142	3,969	1,294	3,145	2,689
97	2,995	3,223	4,070	1,327	3,226	2,757
98	3,071	3,304	4,172	1,360	3,307	2,828
99	3,148	3,387	4,276	1,395	3,390	2,898

Quarterly: 0.2650 Monthly: 0.08330

To calculate a 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 Period, use Preferred rates.

American Continental Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: Entire of State

Male Rates

Rates Effective 8/1/2019

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,310	1,411	1,783	581	1,412	1,141
66	1,310	1,411	1,783	581	1,412	1,141
67	1,310	1,411	1,783	581	1,412	1,141
68	1,325	1,426	1,800	588	1,427	1,181
69	1,354	1,457	1,840	600	1,458	1,229
70	1,387	1,492	1,884	615	1,493	1,274
71	1,430	1,539	1,945	634	1,541	1,321
72	1,476	1,588	2,004	654	1,589	1,366
73	1,524	1,640	2,071	675	1,641	1,411
74	1,576	1,695	2,139	697	1,696	1,458
75	1,633	1,757	2,218	724	1,759	1,507
76	1,690	1,818	2,295	749	1,820	1,555
77	1,748	1,882	2,376	775	1,883	1,606
78	1,809	1,946	2,456	802	1,948	1,660
79	1,868	2,009	2,538	828	2,011	1,716
80	1,927	2,073	2,617	854	2,075	1,773
81	1,986	2,138	2,700	880	2,139	1,828
82	2,049	2,204	2,784	908	2,207	1,887
83	2,112	2,272	2,870	935	2,274	1,945
84	2,177	2,343	2,958	964	2,345	2,004
85	2,250	2,421	3,056	996	2,423	2,072
86	2,314	2,490	3,144	1,025	2,493	2,130
87	2,381	2,560	3,232	1,054	2,563	2,191
88	2,446	2,632	3,324	1,084	2,634	2,252
89	2,514	2,705	3,415	1,114	2,708	2,314
90	2,583	2,780	3,510	1,145	2,782	2,378
91	2,654	2,855	3,606	1,175	2,859	2,443
92	2,726	2,933	3,702	1,208	2,935	2,510
93	2,798	3,011	3,801	1,239	3,014	2,576
94	2,871	3,089	3,901	1,273	3,093	2,645
95	2,947	3,171	4,003	1,306	3,174	2,712
96	3,022	3,252	4,107	1,340	3,255	2,783
97	3,100	3,335	4,212	1,373	3,339	2,854
98	3,179	3,420	4,319	1,408	3,423	2,927
99	3,258	3,506	4,426	1,444	3,509	2,999

Modal Factors: Semi-Annual: 0.5200

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,457	1,568	1,980	646	1,569	1,268
66	1,457	1,568	1,980	646	1,569	1,268
67	1,457	1,568	1,980	646	1,569	1,268
68	1,473	1,584	2,000	653	1,586	1,314
69	1,505	1,618	2,044	668	1,619	1,366
70	1,541	1,659	2,095	683	1,660	1,414
71	1,589	1,711	2,161	704	1,713	1,467
72	1,640	1,765	2,227	727	1,767	1,517
73	1,693	1,821	2,299	750	1,823	1,568
74	1,749	1,882	2,377	775	1,884	1,619
75	1,815	1,952	2,465	804	1,953	1,674
76	1,878	2,020	2,550	832	2,023	1,727
77	1,943	2,091	2,641	861	2,094	1,785
78	2,009	2,162	2,729	890	2,165	1,844
79	2,076	2,233	2,820	919	2,235	1,906
80	2,141	2,304	2,908	948	2,306	1,971
81	2,208	2,376	2,999	979	2,377	2,032
82	2,276	2,449	3,094	1,008	2,452	2,096
83	2,346	2,525	3,190	1,039	2,527	2,161
84	2,418	2,604	3,286	1,071	2,606	2,227
85	2,500	2,689	3,396	1,108	2,693	2,302
86	2,572	2,766	3,493	1,139	2,770	2,367
87	2,645	2,845	3,591	1,171	2,848	2,435
88	2,718	2,926	3,693	1,204	2,928	2,502
89	2,793	3,006	3,795	1,237	3,009	2,572
90	2,870	3,088	3,900	1,271	3,091	2,644
91	2,949	3,172	4,007	1,306	3,176	2,715
92	3,028	3,258	4,114	1,342	3,261	2,788
93	3,109	3,346	4,223	1,377	3,349	2,862
94	3,191	3,433	4,335	1,413	3,436	2,939
95	3,275	3,524	4,448	1,451	3,527	3,014
96	3,358	3,613	4,564	1,488	3,617	3,093
97	3,444	3,707	4,680	1,526	3,710	3,171
98	3,532	3,800	4,799	1,564	3,803	3,252
99	3,620	3,896	4,918	1,604	3,899	3,333

Quarterly: 0.2650 Monthly: 0.08330

To calculate a 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 Period, use Preferred rates.

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 a 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 $1364	$0	$1364 (Part A Deductible)
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	$0	Up to $170.50 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 $185 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	$0	Up to $170.50 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 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 $185 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 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 $185 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$185 (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 $2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2300. 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 $2300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2300 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 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 $185 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 $2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2300. 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 $2300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2300 DEDUCTIBLE*** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$185 (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 $2300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2300 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $185 of Medicare Approved amounts*	$0	$185 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2300 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2300 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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 services	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 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 $185 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 services	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 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 $185 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (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