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# Outline of Coverage

## Medicare Supplement Insurance

**BENEFIT PLANS A, B, F, HIGH DEDUCTIBLE F, G, N**

Underwritten by

An Aetna Company **American Continental Insurance Company**

**NORTH DAKOTA**

**AMERICAN CONTINENTAL INSURANCE COMPANY**
**OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 2**
**BENEFIT PLANS AVAILABLE: A, B, F, HIGH DEDUCTIBLE F, G, N**

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

**See Outlines of Coverage sections for details about ALL plans**

**Basic Benefits:**
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-Approved expenses) or, copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of coinsurance or copayments
Blood: First three pints of blood each year.
Hospice: Part A coinsurance

| A | B | C | D | F/F* | G | K | L | M | N |
|---|---|---|---|---|---|---|---|---|---|
| Basic, including 100% Part B coinsurance | Basic, including 100% Part B coinsurance | Basic, including 100% Part B coinsurance | Basic, including 100% Part B coinsurance | Basic, including 100% Part B coinsurance | Basic, including 100% Part B coinsurance | Hospitalization and preventive care paid at 100%; other basic benefits paid at 50% | Hospitalization and preventive care paid at 100%; other basic benefits paid at 75% | Basic, including 100% Part B coinsurance | Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER |
| | | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | 50% Skilled Nursing Facility Coinsurance | 75% Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance | Skilled Nursing Facility Coinsurance |
| | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | Part A Deductible | 50% Part A Deductible | 75% Part A Deductible | 50% Part A Deductible | Part A Deductible |
| | | Part B Deductible | | Part B Deductible | | | | | |
| | | | | Part B Excess (100%) | Part B Excess (100%) | | | | |
| | | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency | Foreign Travel Emergency | | | Foreign Travel Emergency | Foreign Travel Emergency |
| | | | | | | Out-of-pocket limit $5,120; paid at 100% after limit reached | Out-of-pocket limit $2,560; paid at 100% after limit reached | | |

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,200 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2,200. 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.

**American Continental Insurance Company**

Annual Attained Age Premiums

For Use in ZIP Codes: Entire State

Female Rates

Rates Effective 6/1/2017

| Attained Age | Non-Tobacco | | | | | |
|---|---|---|---|---|---|---|
| | Plan A | Plan B | Plan F | Plan HF | Plan G | Plan N |
| 65 | 1,261 | 1,590 | 1,898 | 616 | 1,257 | 1,029 |
| 66 | 1,261 | 1,590 | 1,898 | 616 | 1,257 | 1,029 |
| 67 | 1,261 | 1,590 | 1,898 | 616 | 1,257 | 1,029 |
| 68 | 1,315 | 1,656 | 1,976 | 643 | 1,309 | 1,072 |
| 69 | 1,373 | 1,731 | 2,053 | 667 | 1,367 | 1,119 |
| 70 | 1,428 | 1,800 | 2,128 | 692 | 1,421 | 1,165 |
| 71 | 1,482 | 1,867 | 2,202 | 716 | 1,476 | 1,209 |
| 72 | 1,534 | 1,932 | 2,272 | 738 | 1,528 | 1,251 |
| 73 | 1,583 | 1,993 | 2,333 | 758 | 1,576 | 1,290 |
| 74 | 1,629 | 2,052 | 2,394 | 778 | 1,621 | 1,327 |
| 75 | 1,669 | 2,104 | 2,447 | 796 | 1,663 | 1,362 |
| 76 | 1,708 | 2,151 | 2,495 | 813 | 1,700 | 1,393 |
| 77 | 1,744 | 2,196 | 2,539 | 825 | 1,737 | 1,424 |
| 78 | 1,776 | 2,238 | 2,577 | 838 | 1,771 | 1,451 |
| 79 | 1,811 | 2,280 | 2,614 | 849 | 1,801 | 1,475 |
| 80 | 1,839 | 2,315 | 2,646 | 860 | 1,830 | 1,499 |
| 81 | 1,864 | 2,346 | 2,680 | 871 | 1,857 | 1,521 |
| 82 | 1,889 | 2,379 | 2,715 | 884 | 1,881 | 1,541 |
| 83 | 1,916 | 2,411 | 2,746 | 893 | 1,905 | 1,561 |
| 84 | 1,937 | 2,440 | 2,780 | 904 | 1,929 | 1,581 |
| 85 | 1,959 | 2,470 | 2,810 | 914 | 1,952 | 1,599 |
| 86 | 1,982 | 2,497 | 2,838 | 923 | 1,974 | 1,616 |
| 87 | 2,003 | 2,525 | 2,868 | 932 | 1,993 | 1,634 |
| 88 | 2,024 | 2,549 | 2,893 | 942 | 2,015 | 1,651 |
| 89 | 2,041 | 2,574 | 2,917 | 949 | 2,035 | 1,666 |
| 90 | 2,059 | 2,596 | 2,943 | 957 | 2,052 | 1,681 |
| 91 | 2,077 | 2,618 | 2,966 | 964 | 2,070 | 1,694 |
| 92 | 2,093 | 2,638 | 2,985 | 970 | 2,083 | 1,706 |
| 93 | 2,106 | 2,656 | 3,003 | 978 | 2,100 | 1,720 |
| 94 | 2,123 | 2,672 | 3,018 | 981 | 2,113 | 1,730 |
| 95 | 2,134 | 2,687 | 3,035 | 987 | 2,126 | 1,741 |
| 96 | 2,147 | 2,705 | 3,051 | 992 | 2,138 | 1,751 |
| 97 | 2,159 | 2,720 | 3,068 | 998 | 2,150 | 1,760 |
| 98 | 2,171 | 2,735 | 3,083 | 1,002 | 2,162 | 1,771 |
| 99 | 2,185 | 2,752 | 3,097 | 1,007 | 2,177 | 1,782 |

| Attained Age | Tobacco | | | | | |
|---|---|---|---|---|---|---|
| | Plan A | Plan B | Plan F | Plan HF | Plan G | Plan N |
| 65 | 1,402 | 1,766 | 2,109 | 685 | 1,395 | 1,143 |
| 66 | 1,402 | 1,766 | 2,109 | 685 | 1,395 | 1,143 |
| 67 | 1,402 | 1,766 | 2,109 | 685 | 1,395 | 1,143 |
| 68 | 1,461 | 1,840 | 2,195 | 713 | 1,454 | 1,192 |
| 69 | 1,526 | 1,922 | 2,283 | 743 | 1,521 | 1,245 |
| 70 | 1,586 | 1,998 | 2,366 | 768 | 1,580 | 1,294 |
| 71 | 1,646 | 2,077 | 2,447 | 796 | 1,640 | 1,342 |
| 72 | 1,705 | 2,148 | 2,523 | 820 | 1,698 | 1,390 |
| 73 | 1,757 | 2,214 | 2,593 | 843 | 1,751 | 1,434 |
| 74 | 1,811 | 2,280 | 2,659 | 865 | 1,801 | 1,476 |
| 75 | 1,853 | 2,336 | 2,720 | 885 | 1,846 | 1,512 |
| 76 | 1,897 | 2,390 | 2,770 | 901 | 1,888 | 1,547 |
| 77 | 1,939 | 2,441 | 2,819 | 916 | 1,930 | 1,581 |
| 78 | 1,975 | 2,489 | 2,865 | 931 | 1,968 | 1,611 |
| 79 | 2,009 | 2,532 | 2,903 | 944 | 2,001 | 1,638 |
| 80 | 2,041 | 2,574 | 2,940 | 956 | 2,035 | 1,666 |
| 81 | 2,071 | 2,609 | 2,978 | 968 | 2,063 | 1,691 |
| 82 | 2,099 | 2,645 | 3,016 | 981 | 2,091 | 1,713 |
| 83 | 2,126 | 2,680 | 3,052 | 992 | 2,117 | 1,734 |
| 84 | 2,153 | 2,712 | 3,089 | 1,003 | 2,145 | 1,755 |
| 85 | 2,177 | 2,744 | 3,123 | 1,015 | 2,169 | 1,776 |
| 86 | 2,202 | 2,775 | 3,154 | 1,026 | 2,194 | 1,797 |
| 87 | 2,226 | 2,802 | 3,186 | 1,035 | 2,217 | 1,816 |
| 88 | 2,247 | 2,832 | 3,215 | 1,045 | 2,239 | 1,833 |
| 89 | 2,270 | 2,859 | 3,242 | 1,055 | 2,259 | 1,850 |
| 90 | 2,291 | 2,884 | 3,269 | 1,063 | 2,280 | 1,867 |
| 91 | 2,309 | 2,908 | 3,294 | 1,071 | 2,298 | 1,881 |
| 92 | 2,325 | 2,931 | 3,318 | 1,080 | 2,315 | 1,897 |
| 93 | 2,342 | 2,950 | 3,338 | 1,085 | 2,332 | 1,909 |
| 94 | 2,358 | 2,970 | 3,356 | 1,091 | 2,347 | 1,924 |
| 95 | 2,372 | 2,989 | 3,372 | 1,097 | 2,360 | 1,935 |
| 96 | 2,383 | 3,006 | 3,389 | 1,102 | 2,375 | 1,945 |
| 97 | 2,400 | 3,023 | 3,407 | 1,108 | 2,389 | 1,956 |
| 98 | 2,412 | 3,040 | 3,426 | 1,114 | 2,402 | 1,967 |
| 99 | 2,428 | 3,059 | 3,443 | 1,119 | 2,417 | 1,981 |

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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

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

**American Continental Insurance Company**

Annual Attained Age Premiums

For Use in ZIP Codes: Entire State

Male Rates

Rates Effective 6/1/2017

| Attained Age | Non-Tobacco | | | | | |
|---|---|---|---|---|---|---|
| | Plan A | Plan B | Plan F | Plan HF | Plan G | Plan N |
| 65 | 1,451 | 1,827 | 2,183 | 710 | 1,444 | 1,183 |
| 66 | 1,451 | 1,827 | 2,183 | 710 | 1,444 | 1,183 |
| 67 | 1,451 | 1,827 | 2,183 | 710 | 1,444 | 1,183 |
| 68 | 1,510 | 1,905 | 2,272 | 738 | 1,505 | 1,233 |
| 69 | 1,578 | 1,991 | 2,360 | 768 | 1,573 | 1,289 |
| 70 | 1,642 | 2,069 | 2,448 | 796 | 1,635 | 1,340 |
| 71 | 1,706 | 2,148 | 2,533 | 824 | 1,698 | 1,390 |
| 72 | 1,765 | 2,223 | 2,614 | 849 | 1,756 | 1,438 |
| 73 | 1,819 | 2,292 | 2,682 | 871 | 1,811 | 1,484 |
| 74 | 1,872 | 2,360 | 2,754 | 896 | 1,865 | 1,527 |
| 75 | 1,920 | 2,417 | 2,815 | 915 | 1,912 | 1,566 |
| 76 | 1,962 | 2,473 | 2,868 | 932 | 1,954 | 1,601 |
| 77 | 2,004 | 2,526 | 2,917 | 949 | 1,998 | 1,635 |
| 78 | 2,045 | 2,576 | 2,965 | 964 | 2,036 | 1,668 |
| 79 | 2,079 | 2,620 | 3,006 | 978 | 2,071 | 1,697 |
| 80 | 2,114 | 2,663 | 3,044 | 989 | 2,105 | 1,724 |
| 81 | 2,143 | 2,702 | 3,083 | 1,002 | 2,134 | 1,748 |
| 82 | 2,172 | 2,737 | 3,123 | 1,015 | 2,164 | 1,771 |
| 83 | 2,202 | 2,774 | 3,159 | 1,027 | 2,191 | 1,794 |
| 84 | 2,227 | 2,804 | 3,196 | 1,040 | 2,219 | 1,816 |
| 85 | 2,254 | 2,839 | 3,232 | 1,051 | 2,244 | 1,839 |
| 86 | 2,280 | 2,870 | 3,264 | 1,062 | 2,270 | 1,859 |
| 87 | 2,304 | 2,904 | 3,298 | 1,073 | 2,294 | 1,878 |
| 88 | 2,327 | 2,932 | 3,327 | 1,082 | 2,317 | 1,898 |
| 89 | 2,346 | 2,960 | 3,359 | 1,091 | 2,339 | 1,917 |
| 90 | 2,370 | 2,986 | 3,385 | 1,100 | 2,360 | 1,932 |
| 91 | 2,389 | 3,010 | 3,409 | 1,108 | 2,379 | 1,948 |
| 92 | 2,405 | 3,033 | 3,431 | 1,115 | 2,398 | 1,963 |
| 93 | 2,424 | 3,055 | 3,454 | 1,124 | 2,413 | 1,977 |
| 94 | 2,440 | 3,074 | 3,473 | 1,130 | 2,429 | 1,990 |
| 95 | 2,452 | 3,091 | 3,492 | 1,135 | 2,444 | 2,002 |
| 96 | 2,468 | 3,109 | 3,508 | 1,141 | 2,457 | 2,013 |
| 97 | 2,482 | 3,126 | 3,525 | 1,147 | 2,472 | 2,025 |
| 98 | 2,497 | 3,146 | 3,545 | 1,153 | 2,486 | 2,037 |
| 99 | 2,512 | 3,165 | 3,562 | 1,157 | 2,502 | 2,049 |

Modal Factors: Semi-Annual: 0.5200

| Attained Age | Tobacco | | | | | |
|---|---|---|---|---|---|---|
| | Plan A | Plan B | Plan F | Plan HF | Plan G | Plan N |
| 65 | 1,612 | 2,030 | 2,424 | 788 | 1,604 | 1,315 |
| 66 | 1,612 | 2,030 | 2,424 | 788 | 1,604 | 1,315 |
| 67 | 1,612 | 2,030 | 2,424 | 788 | 1,604 | 1,315 |
| 68 | 1,680 | 2,116 | 2,524 | 820 | 1,672 | 1,369 |
| 69 | 1,753 | 2,211 | 2,623 | 853 | 1,747 | 1,431 |
| 70 | 1,825 | 2,298 | 2,720 | 885 | 1,816 | 1,489 |
| 71 | 1,895 | 2,387 | 2,815 | 915 | 1,886 | 1,544 |
| 72 | 1,959 | 2,470 | 2,903 | 944 | 1,952 | 1,599 |
| 73 | 2,022 | 2,547 | 2,980 | 969 | 2,013 | 1,648 |
| 74 | 2,079 | 2,620 | 3,057 | 995 | 2,071 | 1,697 |
| 75 | 2,133 | 2,686 | 3,126 | 1,017 | 2,123 | 1,740 |
| 76 | 2,183 | 2,749 | 3,187 | 1,037 | 2,172 | 1,780 |
| 77 | 2,228 | 2,810 | 3,242 | 1,055 | 2,219 | 1,816 |
| 78 | 2,270 | 2,860 | 3,293 | 1,070 | 2,261 | 1,852 |
| 79 | 2,310 | 2,911 | 3,339 | 1,085 | 2,300 | 1,884 |
| 80 | 2,346 | 2,958 | 3,380 | 1,100 | 2,338 | 1,916 |
| 81 | 2,382 | 3,001 | 3,426 | 1,114 | 2,373 | 1,943 |
| 82 | 2,413 | 3,040 | 3,469 | 1,129 | 2,404 | 1,968 |
| 83 | 2,446 | 3,080 | 3,511 | 1,142 | 2,434 | 1,994 |
| 84 | 2,474 | 3,118 | 3,552 | 1,154 | 2,465 | 2,020 |
| 85 | 2,505 | 3,154 | 3,591 | 1,167 | 2,495 | 2,042 |
| 86 | 2,532 | 3,193 | 3,629 | 1,180 | 2,522 | 2,065 |
| 87 | 2,558 | 3,224 | 3,663 | 1,191 | 2,549 | 2,088 |
| 88 | 2,585 | 3,256 | 3,698 | 1,202 | 2,575 | 2,109 |
| 89 | 2,609 | 3,286 | 3,731 | 1,213 | 2,598 | 2,128 |
| 90 | 2,630 | 3,316 | 3,760 | 1,222 | 2,623 | 2,148 |
| 91 | 2,655 | 3,345 | 3,789 | 1,232 | 2,643 | 2,166 |
| 92 | 2,676 | 3,370 | 3,814 | 1,239 | 2,663 | 2,183 |
| 93 | 2,694 | 3,392 | 3,838 | 1,247 | 2,682 | 2,196 |
| 94 | 2,711 | 3,414 | 3,858 | 1,255 | 2,700 | 2,211 |
| 95 | 2,726 | 3,437 | 3,879 | 1,261 | 2,716 | 2,223 |
| 96 | 2,743 | 3,456 | 3,899 | 1,267 | 2,730 | 2,236 |
| 97 | 2,759 | 3,477 | 3,916 | 1,274 | 2,747 | 2,250 |
| 98 | 2,775 | 3,496 | 3,937 | 1,280 | 2,764 | 2,264 |
| 99 | 2,791 | 3,517 | 3,957 | 1,286 | 2,780 | 2,276 |

Quarterly: 0.2650 Monthly: 0.0833

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

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

## 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 $1,316 | $0 | $1,316 (Part A Deductible) |
| 61st thru 90th day | All but $329 a day | $329 a day | $0 |
| 91st day and after | | | |
| •While using 60 lifetime reserve days | All but $658 a day | $658 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 $164.50 a day | $0 | Up to $164.50 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 $183 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 $183 of Medicare-Approved amounts* | $0 | $0 | $183 (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 $183 of Medicare-Approved amounts* | $0 | $0 | $183 (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 $183of Medicare Approved amounts* | $0 | $0 | $183 (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 $1,316 | $1,316 (Part A Deductible) | $0 |
| 61st thru 90th day | All but $329 a day | $329 a day | $0 |
| 91st day and after | | | |
| •While using 60 lifetime reserve days | All but $658 a day | $658 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 $164.50 a day | $0 | Up to $164.50 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 $183 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 $183 of Medicare-Approved amounts* | $0 | $0 | $183 (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 $183 of Medicare-Approved amounts* | $0 | $0 | $183 (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 $183 of Medicare Approved amounts* | $0 | $0 | $183 (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 $1,316 | $1,316 (Part A Deductible) | $0 |
| 61st thru 90th day | All but $329 a day | $329 a day | $0 |
| 91st day and after | | | |
| •While using 60 lifetime reserve days | All but $658 a day | $658 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 $164.50 a day | Up to $164.50 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 $183 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 $183 of Medicare-Approved amounts* | $0 | $183 (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 $183 of Medicare-Approved amounts* | $0 | $183 (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 $183 of Medicare Approved amounts* | $0 | $183 (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**<br>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 $2,200 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,200. 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 $2,200 DEDUCTIBLE*** PLAN PAYS | IN ADDITION TO $2,200 DEDUCTIBLE*** YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,316 | $1,316 (Part A Deductible) | $0 |
| 61st thru 90th day | All but $329 a day | $329 a day | $0 |
| 91st day and after | | | |
| •While using 60 lifetime reserve days | All but $658 a day | $658 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 $164.50 a day | Up to $164.50 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**<br>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 $183 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 $2,200 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,200. 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 $2,200 DEDUCTIBLE*** PLAN PAYS | IN ADDITION TO $2,200 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 $183 of Medicare-Approved amounts* | $0 | $183 (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 $183 of Medicare-Approved amounts* | $0 | $183 (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 $2,200 DEDUCTIBLE*** PLAN PAYS | IN ADDITION TO $2,200 DEDUCTIBLE*** YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE –** MEDICARE APPROVED SERVICES | | | |
| •Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| •Durable medical equipment | | | |
| •First $183 of Medicare Approved amounts* | $0 | $183 (Part B Deductible) | $0 |
| •Remainder of Medicare Approved amounts | 80% | 20% | $0 |

### OTHER BENEFITS – NOT COVERED BY MEDICARE

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $2,200 DEDUCTIBLE** PLAN PAYS | IN ADDITION TO $2,200 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 $1,316 | $1,316 (Part A Deductible) | $0 |
| 61st thru 90th day | All but $329 a day | $329 a day | $0 |
| 91st day and after | | | |
| •While using 60 lifetime reserve days | All but $658 a day | $658 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 $164.50 a day | Up to $164.50 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 $183 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 $183 of Medicare-Approved amounts* | $0 | $0 | $183 (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 $183 of Medicare-Approved amounts* | $0 | $0 | $183 (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 $183 of Medicare Approved amounts* | $0 | $0 | $183 (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**<br>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 $1,316 | $1,316 (Part A Deductible) | $0 |
| 61st thru 90th day | All but $329 a day | $329 a day | $0 |
| 91st day and after | | | |
| •While using 60 lifetime reserve days | All but $658 a day | $658 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 $164.50 a day | Up to $164.50 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 $183 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 $183 of Medicare-Approved amounts* | $0 | $0 | $183 (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 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. | 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 $183 of Medicare-Approved amounts* | $0 | $0 | $183 (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<br>•First $183 of Medicare Approved amounts* | $0 | $0 | $183 (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 |