

## **American Continental Insurance Company**

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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**

**UTAH**



**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 \$4960; paid at 100% after limit reached	Out-of-pocket limit \$2480; 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 \$2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2180. 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: All

Female Rates

Rates Effective 9/1/2016

Attained Age	Preferred					Standard							
	Plan A	Plan B	Plan F	Plan HF	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan N			
65	1,123	1,386	1,693	662	1,144	1,082	1,249	1,539	1,880	735	1,272	1,201	
66	1,123	1,386	1,693	662	1,144	1,082	1,249	1,539	1,880	735	1,272	1,201	
67	1,123	1,386	1,693	662	1,144	1,082	1,249	1,539	1,880	735	1,272	1,201	
68	1,172	1,444	1,761	690	1,193	1,127	1,301	1,604	1,957	766	1,325	1,250	
69	1,223	1,507	1,830	717	1,246	1,176	1,358	1,676	2,034	798	1,384	1,307	
70	1,273	1,568	1,897	742	1,295	1,225	1,413	1,742	2,107	827	1,439	1,359	
71	1,320	1,626	1,964	766	1,344	1,271	1,464	1,808	2,180	855	1,495	1,410	
72	1,367	1,683	2,025	791	1,392	1,315	1,515	1,872	2,249	882	1,547	1,458	
73	1,410	1,737	2,080	813	1,435	1,358	1,564	1,931	2,311	905	1,596	1,506	
74	1,450	1,787	2,133	834	1,477	1,396	1,608	1,986	2,370	928	1,641	1,548	
75	1,487	1,832	2,180	851	1,514	1,431	1,648	2,035	2,424	949	1,682	1,587	
76	1,521	1,874	2,223	869	1,549	1,464	1,686	2,081	2,472	968	1,721	1,624	
77	1,553	1,914	2,261	884	1,582	1,495	1,722	2,125	2,514	985	1,757	1,659	
78	1,583	1,951	2,296	897	1,612	1,523	1,755	2,167	2,552	1,000	1,792	1,692	
79	1,611	1,984	2,329	911	1,640	1,550	1,786	2,204	2,590	1,013	1,823	1,721	
80	1,638	2,017	2,359	921	1,666	1,576	1,814	2,239	2,622	1,027	1,853	1,748	
81	1,661	2,046	2,389	932	1,691	1,599	1,840	2,273	2,656	1,038	1,880	1,774	
82	1,683	2,073	2,418	945	1,714	1,620	1,865	2,303	2,689	1,051	1,904	1,797	
83	1,705	2,099	2,448	956	1,736	1,641	1,889	2,333	2,721	1,064	1,928	1,820	
84	1,726	2,124	2,477	968	1,757	1,661	1,911	2,363	2,755	1,077	1,953	1,843	
85	1,748	2,150	2,505	977	1,779	1,682	1,934	2,391	2,785	1,088	1,976	1,865	
86	1,765	2,174	2,529	987	1,798	1,700	1,955	2,416	2,813	1,099	1,997	1,885	
87	1,783	2,196	2,557	998	1,817	1,718	1,976	2,441	2,843	1,110	2,017	1,906	
88	1,802	2,219	2,579	1,005	1,836	1,736	1,996	2,466	2,868	1,119	2,038	1,925	
89	1,819	2,239	2,601	1,013	1,853	1,752	2,016	2,490	2,893	1,128	2,059	1,944	
90	1,836	2,260	2,624	1,022	1,868	1,766	2,033	2,511	2,915	1,138	2,075	1,960	
91	1,851	2,279	2,644	1,030	1,885	1,781	2,049	2,534	2,939	1,147	2,092	1,978	
92	1,866	2,296	2,660	1,036	1,897	1,794	2,065	2,551	2,958	1,153	2,108	1,992	
93	1,879	2,313	2,678	1,043	1,912	1,807	2,079	2,570	2,978	1,162	2,124	2,007	
94	1,892	2,328	2,690	1,047	1,925	1,818	2,094	2,588	2,991	1,167	2,138	2,021	
95	1,903	2,341	2,706	1,054	1,936	1,828	2,105	2,602	3,009	1,175	2,151	2,032	
96	1,912	2,353	2,719	1,060	1,946	1,838	2,117	2,615	3,023	1,180	2,162	2,045	
97	1,925	2,369	2,734	1,065	1,959	1,849	2,131	2,633	3,038	1,186	2,177	2,058	
98	1,935	2,381	2,748	1,071	1,969	1,859	2,142	2,647	3,054	1,193	2,189	2,070	
99	1,948	2,395	2,761	1,075	1,981	1,869	2,154	2,662	3,068	1,199	2,203	2,083	
Modal Factors:	Semi-Annual:					0.5200	Monthly:					0.0833	
							Quarterly: 0.2650						

The rates do not include the \$20 policy fee.

To calculate household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)

Modal premium x .95 = discounted premium

If applying during Open Enrollment or GI situation use Preferred Rates

# American Continental Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: All

Male Rates

Rates Effective 9/1/2016

Attained Age	Preferred					Standard				
	Plan A	Plan B	Plan F	Plan HF	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan N
65	1,292	1,592	1,946	761	1,317	1,435	1,771	2,161	846	1,462
66	1,292	1,592	1,946	761	1,317	1,435	1,771	2,161	846	1,462
67	1,292	1,592	1,946	761	1,317	1,435	1,771	2,161	846	1,462
68	1,346	1,659	2,027	792	1,372	1,496	1,845	2,250	883	1,523
69	1,406	1,733	2,106	822	1,432	1,563	1,926	2,338	917	1,592
70	1,462	1,802	2,181	854	1,490	1,624	2,004	2,424	950	1,656
71	1,518	1,871	2,257	884	1,545	1,686	2,079	2,509	984	1,718
72	1,571	1,935	2,328	912	1,601	1,744	2,152	2,588	1,014	1,778
73	1,621	1,997	2,391	935	1,651	1,801	2,221	2,658	1,042	1,834
74	1,667	2,055	2,452	960	1,698	1,851	2,283	2,727	1,069	1,886
75	1,710	2,106	2,509	983	1,741	1,898	2,341	2,788	1,092	1,932
76	1,750	2,154	2,557	1,002	1,781	1,944	2,395	2,843	1,115	1,978
77	1,787	2,201	2,601	1,019	1,818	1,984	2,447	2,893	1,135	2,019
78	1,820	2,242	2,641	1,034	1,855	2,023	2,493	2,936	1,151	2,059
79	1,851	2,281	2,679	1,049	1,886	2,059	2,536	2,978	1,167	2,094
80	1,881	2,318	2,713	1,062	1,916	2,091	2,577	3,015	1,183	2,127
81	1,909	2,352	2,747	1,075	1,944	2,122	2,615	3,053	1,198	2,159
82	1,934	2,383	2,783	1,089	1,969	2,150	2,650	3,092	1,213	2,188
83	1,960	2,414	2,817	1,102	1,995	2,178	2,684	3,129	1,228	2,216
84	1,984	2,445	2,850	1,115	2,019	2,204	2,718	3,166	1,242	2,244
85	2,008	2,475	2,881	1,127	2,044	2,231	2,751	3,201	1,257	2,271
86	2,031	2,500	2,910	1,140	2,066	2,255	2,780	3,232	1,269	2,296
87	2,051	2,527	2,941	1,151	2,088	2,279	2,811	3,267	1,282	2,320
88	2,074	2,554	2,967	1,162	2,109	2,303	2,841	3,295	1,294	2,345
89	2,094	2,578	2,992	1,173	2,128	2,325	2,868	3,323	1,306	2,366
90	2,112	2,600	3,018	1,183	2,148	2,345	2,891	3,350	1,317	2,386
91	2,131	2,622	3,042	1,192	2,165	2,365	2,915	3,378	1,329	2,406
92	2,147	2,642	3,060	1,199	2,181	2,381	2,938	3,398	1,336	2,423
93	2,162	2,661	3,081	1,206	2,196	2,398	2,959	3,421	1,345	2,441
94	2,178	2,679	3,096	1,213	2,211	2,414	2,980	3,438	1,350	2,457
95	2,189	2,693	3,112	1,220	2,224	2,428	2,995	3,458	1,359	2,472
96	2,201	2,709	3,129	1,226	2,237	2,442	3,011	3,475	1,366	2,486
97	2,216	2,726	3,144	1,231	2,250	2,459	3,030	3,493	1,373	2,503
98	2,227	2,740	3,163	1,237	2,263	2,471	3,047	3,513	1,380	2,516
99	2,239	2,757	3,177	1,243	2,276	2,488	3,066	3,528	1,387	2,531

Quarterly: 0.2650 Monthly: 0.0833

The rates do not include the \$20 policy fee.

To calculate household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)

Modal premium x .95 = discounted premium

If applying during Open Enrollment or GI situation 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 a 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) be someone with whom you are in a civil union partnership; or (c) be a permanent resident in your home. The household discount will only be applicable if a policy for each applicant is issued. The discounted rate will be 5 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 CALENDAR YEAR

\*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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$0  \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$1288 (Part A Deductible) \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0 \$0 \$0	\$0 Up to \$161 a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 \$166 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
<b>MEDICAL EXPENSES –</b> 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 \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$0  Generally 20%	\$166 (Part B Deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0  80%	All costs \$0  20%	\$0 \$166 (Part B Deductible)  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE –</b> MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies  •Durable medical equipment •First \$166 of Medicare Approved amounts*  •Remainder of Medicare Approved amounts	100%  \$0  80%	\$0  \$0  20%	\$0  \$166 (Part B Deductible)  \$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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1288 (Part A Deductible) \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0  \$0 \$0	\$0  Up to \$161 a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 \$166 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
<b>MEDICAL EXPENSES –</b> 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 \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$0  Generally 20%	\$166 (Part B Deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0  80%	All costs \$0  20%	\$0 \$166 (Part B Deductible)  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE –</b> MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies  •Durable medical equipment •First \$166 of Medicare Approved amounts*  •Remainder of Medicare Approved amounts	100%  \$0  80%	\$0  \$0  20%	\$0  \$166 (Part B Deductible)  \$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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1288 (Part A Deductible) \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0  Up to \$161 a day \$0	\$0  \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 \$166 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
<b>MEDICAL EXPENSES –</b> 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 \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	    \$0   Generally 80%	    \$166 (Part B Deductible)   Generally 20%	    \$0   \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	 \$0 \$0  80%	 All costs \$166 (Part B Deductible)  20%	 \$0 \$0  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE –</b> MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies  •Durable medical equipment •First \$166 of Medicare Approved amounts*  •Remainder of Medicare Approved amounts	 100%   \$0  80%	 \$0   \$166 (Part B Deductible)  20%	 \$0   \$0  \$0

**PLAN F**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	     \$0 \$0	     \$0 80% to a lifetime maximum benefit of \$50,000	     \$250 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 \$2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are \$2180. 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 \$2180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2180 DEDUCTIBLE** YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1288 (Part A Deductible) \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0  Up to \$161 a day \$0	\$0  \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

<b>HOSPICE CARE</b> 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
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**\*\*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 \$166 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 \$2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are \$2180. 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 \$2180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2180 DEDUCTIBLE** YOU PAY
<b>MEDICAL EXPENSES –</b> 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 \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$166 (Part B Deductible)  Generally 20%	\$0  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0  80%	All costs \$166 (Part B Deductible)  20%	\$0 \$0  \$0
<b>CLINICAL LABORATORY            SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0



## HIGH DEDUCTIBLE PLAN F

### PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2180 DEDUCTIBLE** YOU PAY
<b>HOME HEALTH CARE – MEDICARE APPROVED SERVICES</b>			
•Medically necessary skilled care services and medical supplies	100%	\$0	\$0
•Durable medical equipment			
•First \$166 of Medicare Approved amounts*	\$0	\$166 (Part B Deductible)	\$0
•Remainder of Medicare Approved amounts	80%	20%	\$0

### OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2180 DEDUCTIBLE** YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1288 (Part A Deductible) \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0  Up to \$161 a day \$0	\$0  \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 \$166 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
<b>MEDICAL EXPENSES –</b> 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 \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$0  Generally 20%	\$166 (Part B Deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0  80%	All costs \$0  20%	\$0 \$166 (Part B Deductible)  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE –</b> MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies •Durable medical equipment •First \$166 of Medicare Approved amounts* •Remainder of Medicare Approved amounts	100%  \$0  80%	\$0  \$0  20%	\$0  \$166 (Part B Deductible)  \$0

## PLAN G

### OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	     \$0 \$0	     \$0 80% to a lifetime maximum benefit of \$50,000	     \$250 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1288 (Part A Deductible) \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0  Up to \$161 a day \$0	\$0  \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 \$166 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
<b>MEDICAL EXPENSES –</b> 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 \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$0  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.	\$166 (Part B Deductible) 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.
<b>Part B Excess Charges –</b> (Above Medicare-Approved amounts)	\$0	0%	All costs
<b>BLOOD</b> First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0  80%	All costs \$0  20%	\$0 \$166 (Part B Deductible)  \$0
<b>CLINICAL LABORATORY            SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

## PLAN N

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE – MEDICARE APPROVED SERVICES</b>			
•Medically necessary skilled care services and medical supplies	100%	\$0	\$0
•Durable medical equipment			
•First \$166 of Medicare Approved amounts*	\$0	\$0	\$166 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	\$0

### OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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

