



Outline of coverage

Medicare Supplement Insurance

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

Maryland

Underwritten by
Aetna Health Insurance Company

[AetnaSeniorProducts.com](https://www.AetnaSeniorProducts.com)

AETNA HEALTH INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE
BENEFIT PLANS AVAILABLE: A, B, F, G, HIGH DEDUCTIBLE G, N

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

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

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G ¹	K	L	M	N	C	F ¹
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply ³	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2025 ²					\$7,220 ²	\$3,610 ²				

¹ Plans F and G also have a high deductible option, which require first paying a plan deductible of **\$2,870** before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

² Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

³ Plan N pays 100% of the Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that do not result in an inpatient admission.

Aetna Health Insurance Company
Annual premiums
For use in Entire State
Female rates
Rates effective 6/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	5,966	-	-	-	-	-
65	3,696	1,961	2,379	2,181	563	1,407
66	3,696	1,961	2,379	2,181	563	1,407
67	3,696	1,961	2,379	2,181	563	1,407
68	3,735	1,982	2,405	2,204	569	1,455
69	3,820	2,027	2,459	2,255	581	1,516
70	3,922	2,082	2,524	2,314	597	1,574
71	4,040	2,143	2,601	2,384	615	1,628
72	4,167	2,211	2,682	2,458	635	1,685
73	4,301	2,282	2,769	2,539	654	1,741
74	4,452	2,362	2,867	2,627	678	1,800
75	4,607	2,445	2,967	2,721	701	1,858
76	4,769	2,531	3,072	2,814	726	1,917
77	4,938	2,619	3,178	2,915	752	1,982
78	5,106	2,708	3,287	3,012	777	2,048
79	5,265	2,794	3,390	3,108	801	2,114
80	5,429	2,881	3,496	3,206	826	2,185
81	5,600	2,972	3,608	3,307	852	2,254
82	5,768	3,061	3,714	3,403	878	2,321
83	5,945	3,154	3,828	3,509	905	2,391
84	6,119	3,247	3,941	3,611	932	2,461
85	6,342	3,365	4,084	3,743	966	2,552
86	6,523	3,460	4,201	3,851	993	2,625
87	6,708	3,559	4,319	3,959	1,022	2,698
88	6,895	3,658	4,441	4,070	1,049	2,774
89	7,088	3,761	4,564	4,185	1,079	2,851
90	7,282	3,863	4,689	4,298	1,109	2,930
91	7,481	3,970	4,816	4,415	1,139	3,009
92	7,682	4,076	4,946	4,534	1,169	3,090
93	7,886	4,185	5,079	4,655	1,201	3,173
94	8,095	4,296	5,212	4,779	1,232	3,257
95	8,306	4,407	5,349	4,903	1,265	3,342
96	8,521	4,520	5,487	5,029	1,297	3,428
97	8,739	4,636	5,627	5,158	1,330	3,515
98	8,961	4,753	5,769	5,288	1,364	3,605
99+	9,184	4,872	5,914	5,421	1,398	3,695

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	-	-	-	-	-	-
65	4,106	2,178	2,642	2,423	625	1,562
66	4,106	2,178	2,642	2,423	625	1,562
67	4,106	2,178	2,642	2,423	625	1,562
68	4,149	2,202	2,673	2,448	632	1,616
69	4,246	2,253	2,733	2,505	646	1,685
70	4,357	2,313	2,806	2,571	663	1,751
71	4,489	2,382	2,891	2,650	683	1,809
72	4,629	2,457	2,980	2,732	705	1,872
73	4,779	2,535	3,077	2,821	727	1,936
74	4,948	2,625	3,185	2,919	753	2,001
75	5,120	2,717	3,297	3,023	779	2,064
76	5,298	2,811	3,413	3,127	807	2,130
77	5,487	2,911	3,534	3,237	835	2,202
78	5,672	3,008	3,653	3,348	863	2,276
79	5,850	3,104	3,767	3,452	890	2,349
80	6,033	3,200	3,885	3,562	918	2,427
81	6,225	3,303	4,008	3,674	947	2,505
82	6,408	3,401	4,127	3,782	976	2,578
83	6,605	3,507	4,253	3,899	1,006	2,657
84	6,799	3,608	4,377	4,012	1,035	2,735
85	7,047	3,739	4,538	4,158	1,073	2,835
86	7,249	3,844	4,666	4,278	1,103	2,916
87	7,455	3,955	4,798	4,398	1,135	2,999
88	7,664	4,066	4,933	4,522	1,166	3,081
89	7,875	4,179	5,071	4,648	1,199	3,169
90	8,091	4,291	5,209	4,777	1,232	3,255
91	8,312	4,411	5,353	4,905	1,265	3,344
92	8,536	4,529	5,496	5,038	1,299	3,434
93	8,764	4,649	5,643	5,173	1,334	3,525
94	8,995	4,774	5,792	5,309	1,369	3,619
95	9,229	4,896	5,944	5,448	1,405	3,714
96	9,468	5,024	6,097	5,588	1,441	3,807
97	9,711	5,151	6,252	5,730	1,478	3,905
98	9,956	5,282	6,410	5,875	1,516	4,005
99+	10,205	5,413	6,571	6,023	1,553	4,105

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

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 periods, use preferred rates.

Modal factors

Semi-annual0.5200
Quarterly0.2650
Monthly0.0833

Aetna Health Insurance Company

Annual premiums
For use in Entire State
Male rates

Rates effective 6/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	6,860	-	-	-	-	-
65	4,250	2,255	2,735	2,507	647	1,616
66	4,250	2,255	2,735	2,507	647	1,616
67	4,250	2,255	2,735	2,507	647	1,616
68	4,296	2,279	2,765	2,534	654	1,674
69	4,394	2,332	2,827	2,593	669	1,743
70	4,509	2,393	2,903	2,661	686	1,810
71	4,646	2,464	2,992	2,742	707	1,874
72	4,792	2,543	3,084	2,826	730	1,937
73	4,946	2,624	3,185	2,919	752	2,002
74	5,121	2,717	3,297	3,021	779	2,071
75	5,298	2,811	3,413	3,128	806	2,137
76	5,484	2,909	3,533	3,236	835	2,205
77	5,679	3,012	3,657	3,352	864	2,280
78	5,871	3,114	3,780	3,465	893	2,355
79	6,055	3,212	3,899	3,573	922	2,432
80	6,245	3,314	4,021	3,686	950	2,511
81	6,442	3,418	4,147	3,802	980	2,592
82	6,633	3,520	4,271	3,914	1,010	2,668
83	6,838	3,628	4,403	4,035	1,041	2,750
84	7,037	3,733	4,532	4,153	1,071	2,831
85	7,294	3,870	4,696	4,304	1,111	2,934
86	7,501	3,981	4,830	4,429	1,141	3,019
87	7,714	4,092	4,966	4,553	1,175	3,103
88	7,931	4,207	5,107	4,680	1,207	3,190
89	8,150	4,326	5,248	4,811	1,241	3,279
90	8,373	4,443	5,392	4,944	1,275	3,369
91	8,602	4,565	5,539	5,077	1,310	3,461
92	8,834	4,687	5,689	5,213	1,345	3,553
93	9,070	4,812	5,841	5,354	1,381	3,648
94	9,310	4,940	5,994	5,496	1,417	3,745
95	9,553	5,067	6,151	5,637	1,454	3,843
96	9,799	5,199	6,310	5,784	1,491	3,943
97	10,049	5,332	6,470	5,932	1,530	4,043
98	10,305	5,467	6,635	6,082	1,569	4,145
99+	10,562	5,602	6,801	6,234	1,607	4,250

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	-	-	-	-	-	-
65	4,723	2,505	3,039	2,786	718	1,796
66	4,723	2,505	3,039	2,786	718	1,796
67	4,723	2,505	3,039	2,786	718	1,796
68	4,773	2,532	3,073	2,815	726	1,860
69	4,882	2,590	3,142	2,881	743	1,937
70	5,011	2,661	3,225	2,957	763	2,011
71	5,162	2,738	3,325	3,048	786	2,081
72	5,322	2,825	3,427	3,141	810	2,152
73	5,496	2,917	3,538	3,244	836	2,226
74	5,689	3,019	3,662	3,358	867	2,300
75	5,887	3,125	3,792	3,476	896	2,375
76	6,095	3,234	3,926	3,596	929	2,450
77	6,311	3,348	4,064	3,725	960	2,532
78	6,523	3,459	4,201	3,851	993	2,617
79	6,729	3,570	4,332	3,971	1,023	2,701
80	6,939	3,682	4,466	4,096	1,056	2,790
81	7,157	3,799	4,610	4,225	1,089	2,880
82	7,369	3,911	4,746	4,348	1,122	2,966
83	7,596	4,031	4,891	4,482	1,157	3,057
84	7,819	4,149	5,036	4,615	1,191	3,145
85	8,103	4,300	5,218	4,781	1,234	3,260
86	8,335	4,421	5,367	4,920	1,269	3,354
87	8,572	4,546	5,519	5,058	1,305	3,449
88	8,813	4,675	5,675	5,203	1,341	3,544
89	9,056	4,806	5,832	5,345	1,379	3,644
90	9,305	4,936	5,992	5,493	1,417	3,743
91	9,558	5,073	6,155	5,642	1,455	3,847
92	9,817	5,209	6,319	5,793	1,493	3,949
93	10,077	5,348	6,491	5,949	1,534	4,054
94	10,345	5,490	6,661	6,106	1,574	4,162
95	10,614	5,631	6,835	6,265	1,616	4,272
96	10,889	5,777	7,011	6,427	1,657	4,380
97	11,167	5,925	7,190	6,590	1,699	4,491
98	11,449	6,075	7,373	6,757	1,743	4,605
99+	11,736	6,226	7,556	6,926	1,787	4,721

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

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 periods, use preferred rates.

Modal factors

Semi-annual0.5200
Quarterly0.2650
Monthly0.0833

PREMIUM INFORMATION

Aetna Health 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.

Premiums payable other than annually will be determined according to the following factors:

Semi-annual: 0.5200 Quarterly: 0.2650 Monthly EFT: 0.0833.

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 Aetna Health Insurance Company, P.O. Box 14770, Lexington, Kentucky 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 Aetna Health 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, G, HIGH DEDUCTIBLE G and N OFFERED BY AETNA HEALTH INSURANCE COMPANY.

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$0	\$1,676 (Part A Deductible)
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used:			
Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$209.50 a day	\$0	Up to \$209.50 a day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$257 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	\$0

PLAN B

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$1,676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used:			
Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$209.50 a day	\$0	Up to \$209.50 a day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$257 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	\$0

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$1,676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used:			
Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$209.50 a day	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$257 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare-Approved amounts*	\$0	\$257 (Part B Deductible)	\$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$257 of Medicare-Approved amounts*	\$0	\$257 (Part B Deductible)	\$0
Remainder of Medicare-Approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$257 of Medicare-Approved amounts*	\$0	\$257 (Part B Deductible)	\$0
Remainder of Medicare-Approved amounts	80%	20%	\$0

PLAN F
OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$1,676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used:			
Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$209.50 a day	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$257 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	\$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

HIGH DEDUCTIBLE 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.

****This high deductible plan pays the same benefits as Plan G after one has paid a calendar year \$2,870 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are \$2,870. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,870 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,870 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$1,676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used:			
Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$209.50 a day	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$257 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

****This high deductible plan pays the same benefits as Plan G after one has paid a calendar year \$2,870 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are \$2,870. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,870 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,870 DEDUCTIBLE*** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,870 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,870 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,870 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,870 DEDUCTIBLE*** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,676	\$1,676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used:			
Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$209.50 a day	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$257 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The co-payment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN N
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum