



# Outline of coverage

## Medicare Supplement Insurance

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

**Maryland**

Underwritten by

**Aetna Health Insurance Company**

**[AetnaSeniorProducts.com](https://www.aetna.com/seniorproducts)**

**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 <sup>1</sup>	K	L	M	N	C	F <sup>1</sup>
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 <sup>3</sup>	✓	✓
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 2024 <sup>2</sup>					<b>\$7,060<sup>2</sup></b>	<b>\$3,530<sup>2</sup></b>				

<sup>1</sup> Plans F and G also have a high deductible option, which require first paying a plan deductible of **\$2,800** 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.

<sup>2</sup> 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.

<sup>3</sup> 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 6/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	5,473	-	-	-	-	-
65	3,391	1,799	2,183	2,001	625	1,291
66	3,391	1,799	2,183	2,001	625	1,291
67	3,391	1,799	2,183	2,001	625	1,291
68	3,427	1,818	2,206	2,022	632	1,335
69	3,505	1,860	2,256	2,069	646	1,391
70	3,598	1,910	2,316	2,123	663	1,444
71	3,706	1,966	2,386	2,187	683	1,494
72	3,823	2,028	2,461	2,255	705	1,546
73	3,946	2,094	2,540	2,329	727	1,597
74	4,084	2,167	2,630	2,410	753	1,651
75	4,227	2,243	2,722	2,496	779	1,705
76	4,375	2,322	2,818	2,582	807	1,759
77	4,530	2,403	2,916	2,674	835	1,818
78	4,684	2,484	3,016	2,763	863	1,879
79	4,830	2,563	3,110	2,851	890	1,939
80	4,981	2,643	3,207	2,941	918	2,005
81	5,138	2,727	3,310	3,034	947	2,068
82	5,292	2,808	3,407	3,122	976	2,129
83	5,454	2,894	3,512	3,219	1,006	2,194
84	5,614	2,979	3,616	3,313	1,035	2,258
85	5,818	3,087	3,747	3,434	1,073	2,341
86	5,984	3,174	3,854	3,533	1,103	2,408
87	6,154	3,265	3,962	3,632	1,135	2,475
88	6,326	3,356	4,074	3,734	1,166	2,545
89	6,503	3,450	4,187	3,839	1,199	2,616
90	6,681	3,544	4,302	3,943	1,232	2,688
91	6,863	3,642	4,418	4,050	1,265	2,761
92	7,048	3,739	4,538	4,160	1,299	2,835
93	7,235	3,839	4,660	4,271	1,334	2,911
94	7,427	3,941	4,782	4,384	1,369	2,988
95	7,620	4,043	4,907	4,498	1,405	3,066
96	7,817	4,147	5,034	4,614	1,441	3,145
97	8,017	4,253	5,162	4,732	1,478	3,225
98	8,221	4,361	5,293	4,851	1,516	3,307
99+	8,426	4,470	5,426	4,973	1,553	3,390

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	-	-	-	-	-	-
65	3,767	1,998	2,424	2,223	694	1,433
66	3,767	1,998	2,424	2,223	694	1,433
67	3,767	1,998	2,424	2,223	694	1,433
68	3,806	2,020	2,452	2,246	702	1,483
69	3,895	2,067	2,507	2,298	718	1,546
70	3,997	2,122	2,574	2,359	737	1,606
71	4,118	2,185	2,652	2,431	759	1,660
72	4,247	2,254	2,734	2,506	783	1,717
73	4,384	2,326	2,823	2,588	808	1,776
74	4,539	2,408	2,922	2,678	837	1,836
75	4,697	2,493	3,025	2,773	866	1,894
76	4,861	2,579	3,131	2,869	897	1,954
77	5,034	2,671	3,242	2,970	928	2,020
78	5,204	2,760	3,351	3,072	959	2,088
79	5,367	2,848	3,456	3,167	989	2,155
80	5,535	2,936	3,564	3,268	1,020	2,227
81	5,711	3,030	3,677	3,371	1,052	2,298
82	5,879	3,120	3,786	3,470	1,084	2,365
83	6,060	3,217	3,902	3,577	1,118	2,438
84	6,238	3,310	4,016	3,681	1,150	2,509
85	6,465	3,430	4,163	3,815	1,192	2,601
86	6,650	3,527	4,281	3,925	1,226	2,675
87	6,839	3,628	4,402	4,035	1,261	2,751
88	7,031	3,730	4,526	4,149	1,296	2,827
89	7,225	3,834	4,652	4,264	1,332	2,907
90	7,423	3,937	4,779	4,383	1,369	2,986
91	7,626	4,047	4,911	4,500	1,406	3,068
92	7,831	4,155	5,042	4,622	1,443	3,150
93	8,040	4,265	5,177	4,746	1,482	3,234
94	8,252	4,380	5,314	4,871	1,521	3,320
95	8,467	4,492	5,453	4,998	1,561	3,407
96	8,686	4,609	5,594	5,127	1,601	3,493
97	8,909	4,726	5,736	5,257	1,642	3,583
98	9,134	4,846	5,881	5,390	1,684	3,674
99+	9,362	4,966	6,028	5,526	1,726	3,766

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-annual .....0.5200  
 Quarterly .....0.2650  
 Monthly.....0.0833

**Aetna Health Insurance Company**  
 Annual premiums  
 For use in Entire State  
 Male rates  
 Rates effective 6/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	6,294	-	-	-	-	-
65	3,899	2,069	2,509	2,300	719	1,483
66	3,899	2,069	2,509	2,300	719	1,483
67	3,899	2,069	2,509	2,300	719	1,483
68	3,941	2,091	2,537	2,325	727	1,536
69	4,031	2,139	2,594	2,379	743	1,599
70	4,137	2,195	2,663	2,441	762	1,661
71	4,262	2,261	2,745	2,516	785	1,719
72	4,396	2,333	2,829	2,593	811	1,777
73	4,538	2,407	2,922	2,678	836	1,837
74	4,698	2,493	3,025	2,772	866	1,900
75	4,861	2,579	3,131	2,870	896	1,961
76	5,031	2,669	3,241	2,969	928	2,023
77	5,210	2,763	3,355	3,075	960	2,092
78	5,386	2,857	3,468	3,179	992	2,161
79	5,555	2,947	3,577	3,278	1,024	2,231
80	5,729	3,040	3,689	3,382	1,056	2,304
81	5,910	3,136	3,805	3,488	1,089	2,378
82	6,085	3,229	3,918	3,591	1,122	2,448
83	6,273	3,328	4,039	3,702	1,157	2,523
84	6,456	3,425	4,158	3,810	1,190	2,597
85	6,692	3,550	4,308	3,949	1,234	2,692
86	6,882	3,652	4,431	4,063	1,268	2,770
87	7,077	3,754	4,556	4,177	1,305	2,847
88	7,276	3,860	4,685	4,294	1,341	2,927
89	7,477	3,969	4,815	4,414	1,379	3,008
90	7,682	4,076	4,947	4,536	1,417	3,091
91	7,892	4,188	5,082	4,658	1,455	3,175
92	8,105	4,300	5,219	4,783	1,494	3,260
93	8,321	4,415	5,359	4,912	1,534	3,347
94	8,541	4,532	5,499	5,042	1,574	3,436
95	8,764	4,649	5,643	5,172	1,616	3,526
96	8,990	4,770	5,789	5,306	1,657	3,617
97	9,219	4,892	5,936	5,442	1,700	3,709
98	9,454	5,016	6,087	5,580	1,743	3,803
99+	9,690	5,139	6,239	5,719	1,786	3,899

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	-	-	-	-	-	-
65	4,333	2,298	2,788	2,556	798	1,648
66	4,333	2,298	2,788	2,556	798	1,648
67	4,333	2,298	2,788	2,556	798	1,648
68	4,379	2,323	2,819	2,583	807	1,706
69	4,479	2,376	2,883	2,643	826	1,777
70	4,597	2,441	2,959	2,713	848	1,845
71	4,736	2,512	3,050	2,796	873	1,909
72	4,883	2,592	3,144	2,882	900	1,974
73	5,042	2,676	3,246	2,976	929	2,042
74	5,219	2,770	3,360	3,081	963	2,110
75	5,401	2,867	3,479	3,189	996	2,179
76	5,592	2,967	3,602	3,299	1,032	2,248
77	5,790	3,072	3,728	3,417	1,067	2,323
78	5,984	3,173	3,854	3,533	1,103	2,401
79	6,173	3,275	3,974	3,643	1,137	2,478
80	6,366	3,378	4,097	3,758	1,173	2,560
81	6,566	3,485	4,229	3,876	1,210	2,642
82	6,761	3,588	4,354	3,989	1,247	2,721
83	6,969	3,698	4,487	4,112	1,286	2,805
84	7,173	3,806	4,620	4,234	1,323	2,885
85	7,434	3,945	4,787	4,386	1,371	2,991
86	7,647	4,056	4,924	4,514	1,410	3,077
87	7,864	4,171	5,063	4,640	1,450	3,164
88	8,085	4,289	5,206	4,773	1,490	3,251
89	8,308	4,409	5,350	4,904	1,532	3,343
90	8,537	4,528	5,497	5,039	1,574	3,434
91	8,769	4,654	5,647	5,176	1,617	3,529
92	9,006	4,779	5,797	5,315	1,659	3,623
93	9,245	4,906	5,955	5,458	1,704	3,719
94	9,491	5,037	6,111	5,602	1,749	3,818
95	9,738	5,166	6,271	5,748	1,795	3,919
96	9,990	5,300	6,432	5,896	1,841	4,018
97	10,245	5,436	6,596	6,046	1,888	4,120
98	10,504	5,573	6,764	6,199	1,937	4,225
99+	10,767	5,712	6,932	6,354	1,985	4,331

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-annual .....0.5200  
 Quarterly .....0.2650  
 Monthly.....0.0833

## **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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$0	\$1,632 (Part A Deductible)
61st thru 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$816 a day	\$816 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
<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	All approved amounts	\$0	\$0
21st thru 100th day	All but \$204 a day	\$0	Up to \$204 a day
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$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 \$240 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 tests, durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	\$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	100%	\$0	\$0
Durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$1,632 (Part A Deductible)	\$0
61st thru 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$816 a day	\$816 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
<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	All approved amounts	\$0	\$0
21st thru 100th day	All but \$204 a day	\$0	Up to \$204 a day
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$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 B**

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

\*Once you have been billed \$240 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<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 tests, durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE –</b> MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$1,632 (Part A Deductible)	\$0
61st thru 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$816 a day	\$816 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
<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	All approved amounts	\$0	\$0
21st thru 100th day	All but \$204 a day	Up to \$204 a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$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 F**

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

\*Once you have been billed \$240 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 tests, durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$240 (Part B Deductible)	\$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare-Approved amounts*	\$0	\$240 (Part B Deductible)	\$0
Remainder of Medicare-Approved amounts	80%	20%	\$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	100%	\$0	\$0
Durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$240 (Part B Deductible)	\$0
Remainder of Medicare-Approved amounts	80%	20%	\$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	\$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	All but \$1,632	\$1,632 (Part A Deductible)	\$0
61st thru 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$816 a day	\$816 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
<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	All approved amounts	\$0	\$0
21st thru 100th day	All but \$204 a day	Up to \$204 a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$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 G**

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

\*Once you have been billed \$240 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 tests, durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	\$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	100%	\$0	\$0
Durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	\$0

**PLAN G**

**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	\$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 \$2,800 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are \$2,800. 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 \$2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,800 DEDUCTIBLE*** YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$1,632 (Part A Deductible)	\$0
61st thru 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$816 a day	\$816 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
<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	All approved amounts	\$0	\$0
21st thru 100th day	All but \$204 a day	Up to \$204 a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$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.



## HIGH DEDUCTIBLE PLAN G

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

\*Once you have been billed \$240 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 \$2,800 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are \$2,800. 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 \$2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,800 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 tests, durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

## HIGH DEDUCTIBLE PLAN G

### PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,800 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 \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (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 \$2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,800 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 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$1,632 (Part A Deductible)	\$0
61st thru 90th day	All but \$408 a day	\$408 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$816 a day	\$816 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
<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	All approved amounts	\$0	\$0
21st thru 100th day	All but \$204 a day	Up to \$204 a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$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 N**

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

\*Once you have been billed \$240 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 tests, durable medical equipment			
First \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (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.
<b>PART B EXCESS CHARGES</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	\$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 \$240 of Medicare-Approved amounts*	\$0	\$0	\$240 (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