Outline of coverage

Medicare Supplement Insurance

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

South Carolina

Underwritten by

Aetna Health Insurance Company

AetnaSeniorProducts.com

AHCMS04875SC

Rates effective: 04/2024 A

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 2024[2]					**$7,060[2]**	**$3,530[2]**				

[1] 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.

[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 ZIP Codes: 294-295, 298-299
Female rates
Rates effective 4/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,533	1,760	2,025	1,674	560	1,094
66	1,533	1,760	2,025	1,674	560	1,094
67	1,533	1,760	2,025	1,674	560	1,094
68	1,549	1,778	2,048	1,693	566	1,134
69	1,585	1,820	2,095	1,731	579	1,179
70	1,626	1,868	2,149	1,778	594	1,225
71	1,674	1,924	2,215	1,830	613	1,268
72	1,728	1,984	2,284	1,888	631	1,311
73	1,782	2,048	2,358	1,948	652	1,355
74	1,848	2,121	2,441	2,019	675	1,401
75	1,911	2,195	2,526	2,088	699	1,446
76	1,978	2,272	2,614	2,161	723	1,491
77	2,048	2,351	2,708	2,238	749	1,542
78	2,116	2,431	2,798	2,314	774	1,595
79	2,183	2,506	2,889	2,385	798	1,645
80	2,251	2,584	2,977	2,460	823	1,700
81	2,323	2,667	3,073	2,539	849	1,754
82	2,393	2,747	3,162	2,613	874	1,805
83	2,466	2,831	3,260	2,693	901	1,862
84	2,538	2,915	3,354	2,773	928	1,916
85	2,630	3,021	3,476	2,874	961	1,985
86	2,704	3,108	3,575	2,957	989	2,042
87	2,782	3,194	3,678	3,041	1,017	2,100
88	2,859	3,283	3,780	3,125	1,045	2,159
89	2,940	3,375	3,887	3,211	1,075	2,219
90	3,021	3,467	3,993	3,299	1,104	2,279
91	3,101	3,562	4,102	3,390	1,134	2,342
92	3,186	3,658	4,213	3,481	1,164	2,406
93	3,270	3,755	4,326	3,574	1,196	2,470
94	3,357	3,854	4,437	3,669	1,227	2,533
95	3,444	3,956	4,555	3,764	1,259	2,601
96	3,535	4,058	4,672	3,862	1,292	2,668
97	3,624	4,161	4,792	3,960	1,324	2,735
98	3,717	4,267	4,913	4,060	1,358	2,805
99+	3,808	4,372	5,036	4,162	1,392	2,875

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,703	1,955	2,250	1,861	622	1,215
66	1,703	1,955	2,250	1,861	622	1,215
67	1,703	1,955	2,250	1,861	622	1,215
68	1,721	1,975	2,275	1,880	629	1,259
69	1,760	2,022	2,330	1,924	643	1,311
70	1,806	2,074	2,388	1,974	661	1,361
71	1,863	2,139	2,460	2,033	680	1,409
72	1,919	2,204	2,539	2,097	701	1,458
73	1,982	2,276	2,620	2,165	724	1,505
74	2,052	2,355	2,713	2,241	750	1,557
75	2,123	2,438	2,808	2,321	776	1,607
76	2,199	2,522	2,906	2,401	803	1,657
77	2,276	2,613	3,008	2,487	832	1,715
78	2,351	2,700	3,109	2,570	860	1,772
79	2,426	2,784	3,208	2,651	886	1,827
80	2,502	2,873	3,309	2,735	915	1,889
81	2,581	2,964	3,413	2,821	944	1,949
82	2,657	3,051	3,515	2,903	971	2,005
83	2,741	3,145	3,621	2,994	1,002	2,069
84	2,819	3,237	3,727	3,081	1,031	2,129
85	2,923	3,356	3,862	3,193	1,068	2,205
86	3,006	3,452	3,974	3,285	1,099	2,269
87	3,092	3,549	4,085	3,378	1,130	2,334
88	3,176	3,649	4,201	3,473	1,162	2,399
89	3,265	3,751	4,317	3,568	1,195	2,467
90	3,356	3,853	4,435	3,667	1,227	2,532
91	3,445	3,959	4,556	3,767	1,260	2,603
92	3,540	4,065	4,680	3,868	1,294	2,673
93	3,634	4,173	4,805	3,971	1,329	2,745
94	3,729	4,284	4,931	4,077	1,364	2,815
95	3,827	4,396	5,063	4,183	1,398	2,890
96	3,927	4,510	5,191	4,290	1,436	2,964
97	4,025	4,622	5,324	4,401	1,472	3,040
98	4,128	4,739	5,459	4,512	1,509	3,116
99+	4,231	4,858	5,596	4,623	1,547	3,194

The above rates do not include the $20 one-time policy fee.

To calculate a 7% 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 ZIP Codes: 294-295, 298-299
Male rates
Rates effective 4/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,761	2,023	2,332	1,925	644	1,259
66	1,761	2,023	2,332	1,925	644	1,259
67	1,761	2,023	2,332	1,925	644	1,259
68	1,781	2,046	2,355	1,946	651	1,303
69	1,822	2,092	2,409	1,990	666	1,357
70	1,870	2,147	2,471	2,045	683	1,409
71	1,927	2,214	2,546	2,106	704	1,458
72	1,987	2,281	2,627	2,170	726	1,507
73	2,050	2,354	2,711	2,240	750	1,558
74	2,123	2,439	2,808	2,321	776	1,611
75	2,197	2,522	2,906	2,401	803	1,663
76	2,274	2,613	3,008	2,485	831	1,716
77	2,354	2,704	3,112	2,573	861	1,773
78	2,433	2,796	3,219	2,661	891	1,833
79	2,510	2,882	3,319	2,744	918	1,891
80	2,591	2,974	3,423	2,831	946	1,955
81	2,672	3,067	3,534	2,918	977	2,017
82	2,750	3,159	3,636	3,006	1,005	2,075
83	2,835	3,256	3,750	3,099	1,037	2,142
84	2,918	3,353	3,859	3,187	1,067	2,203
85	3,025	3,474	3,997	3,306	1,105	2,282
86	3,110	3,573	4,113	3,400	1,137	2,349
87	3,199	3,674	4,228	3,498	1,170	2,417
88	3,290	3,777	4,348	3,594	1,202	2,482
89	3,379	3,883	4,470	3,694	1,236	2,553
90	3,474	3,987	4,590	3,794	1,270	2,623
91	3,568	4,097	4,716	3,897	1,304	2,694
92	3,662	4,205	4,845	4,001	1,339	2,766
93	3,761	4,319	4,973	4,110	1,376	2,841
94	3,860	4,432	5,106	4,219	1,412	2,914
95	3,961	4,549	5,239	4,329	1,448	2,990
96	4,065	4,666	5,374	4,441	1,486	3,067
97	4,168	4,785	5,510	4,554	1,523	3,146
98	4,272	4,907	5,649	4,670	1,562	3,225
99+	4,381	5,028	5,790	4,786	1,601	3,306

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,957	2,249	2,588	2,139	716	1,398
66	1,957	2,249	2,588	2,139	716	1,398
67	1,957	2,249	2,588	2,139	716	1,398
68	1,979	2,273	2,616	2,164	724	1,448
69	2,023	2,326	2,676	2,213	740	1,507
70	2,079	2,385	2,748	2,270	760	1,565
71	2,141	2,459	2,831	2,339	783	1,620
72	2,206	2,534	2,921	2,413	806	1,675
73	2,279	2,616	3,014	2,488	833	1,730
74	2,362	2,709	3,118	2,579	862	1,790
75	2,443	2,805	3,229	2,668	893	1,848
76	2,529	2,900	3,341	2,761	924	1,906
77	2,616	3,005	3,459	2,860	956	1,971
78	2,704	3,107	3,575	2,956	989	2,037
79	2,790	3,204	3,689	3,049	1,019	2,102
80	2,878	3,304	3,805	3,145	1,052	2,172
81	2,967	3,410	3,926	3,244	1,086	2,241
82	3,056	3,509	4,042	3,338	1,117	2,305
83	3,151	3,618	4,164	3,442	1,152	2,378
84	3,243	3,723	4,286	3,543	1,186	2,448
85	3,359	3,859	4,441	3,671	1,228	2,536
86	3,457	3,971	4,569	3,778	1,263	2,609
87	3,554	4,081	4,701	3,886	1,300	2,684
88	3,654	4,197	4,829	3,994	1,336	2,760
89	3,754	4,313	4,964	4,102	1,373	2,836
90	3,859	4,431	5,099	4,217	1,412	2,912
91	3,962	4,553	5,241	4,331	1,449	2,993
92	4,071	4,673	5,382	4,448	1,488	3,073
93	4,179	4,798	5,526	4,566	1,528	3,156
94	4,289	4,925	5,672	4,688	1,569	3,237
95	4,403	5,054	5,822	4,810	1,608	3,322
96	4,518	5,186	5,969	4,933	1,651	3,408
97	4,629	5,316	6,123	5,062	1,693	3,496
98	4,748	5,450	6,276	5,188	1,735	3,584
99+	4,865	5,587	6,434	5,317	1,779	3,673

The above rates do not include the $20 one-time policy fee.

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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: Rest of State
Female rates
Rates effective 4/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,406	1,615	1,858	1,536	514	1,004
66	1,406	1,615	1,858	1,536	514	1,004
67	1,406	1,615	1,858	1,536	514	1,004
68	1,421	1,631	1,879	1,553	519	1,040
69	1,454	1,670	1,922	1,588	531	1,082
70	1,492	1,714	1,972	1,631	545	1,124
71	1,536	1,765	2,032	1,679	562	1,163
72	1,585	1,820	2,095	1,732	579	1,203
73	1,635	1,879	2,163	1,787	598	1,243
74	1,695	1,946	2,239	1,852	619	1,285
75	1,753	2,014	2,317	1,916	641	1,327
76	1,815	2,084	2,398	1,983	663	1,368
77	1,879	2,157	2,484	2,053	687	1,415
78	1,941	2,230	2,567	2,123	710	1,463
79	2,003	2,299	2,650	2,188	732	1,509
80	2,065	2,371	2,731	2,257	755	1,560
81	2,131	2,447	2,819	2,329	779	1,609
82	2,195	2,520	2,901	2,397	802	1,656
83	2,262	2,597	2,991	2,471	827	1,708
84	2,328	2,674	3,077	2,544	851	1,758
85	2,413	2,772	3,189	2,637	882	1,821
86	2,481	2,851	3,280	2,713	907	1,873
87	2,552	2,930	3,374	2,790	933	1,927
88	2,623	3,012	3,468	2,867	959	1,981
89	2,697	3,096	3,566	2,946	986	2,036
90	2,772	3,181	3,663	3,027	1,013	2,091
91	2,845	3,268	3,763	3,110	1,040	2,149
92	2,923	3,356	3,865	3,194	1,068	2,207
93	3,000	3,445	3,969	3,279	1,097	2,266
94	3,080	3,536	4,071	3,366	1,126	2,324
95	3,160	3,629	4,179	3,453	1,155	2,386
96	3,243	3,723	4,286	3,543	1,185	2,448
97	3,325	3,817	4,396	3,633	1,215	2,509
98	3,410	3,915	4,507	3,725	1,246	2,573
99+	3,494	4,011	4,620	3,818	1,277	2,638

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,562	1,794	2,064	1,707	571	1,115
66	1,562	1,794	2,064	1,707	571	1,115
67	1,562	1,794	2,064	1,707	571	1,115
68	1,579	1,812	2,087	1,725	577	1,155
69	1,615	1,855	2,138	1,765	590	1,203
70	1,657	1,903	2,191	1,811	606	1,249
71	1,709	1,962	2,257	1,865	624	1,293
72	1,761	2,022	2,329	1,924	643	1,338
73	1,818	2,088	2,404	1,986	664	1,381
74	1,883	2,161	2,489	2,056	688	1,428
75	1,948	2,237	2,576	2,129	712	1,474
76	2,017	2,314	2,666	2,203	737	1,520
77	2,088	2,397	2,760	2,282	763	1,573
78	2,157	2,477	2,852	2,358	789	1,626
79	2,226	2,554	2,943	2,432	813	1,676
80	2,295	2,636	3,036	2,509	839	1,733
81	2,368	2,719	3,131	2,588	866	1,788
82	2,438	2,799	3,225	2,663	891	1,839
83	2,515	2,885	3,322	2,747	919	1,898
84	2,586	2,970	3,419	2,827	946	1,953
85	2,682	3,079	3,543	2,929	980	2,023
86	2,758	3,167	3,646	3,014	1,008	2,082
87	2,837	3,256	3,748	3,099	1,037	2,141
88	2,914	3,348	3,854	3,186	1,066	2,201
89	2,995	3,441	3,961	3,273	1,096	2,263
90	3,079	3,535	4,069	3,364	1,126	2,323
91	3,161	3,632	4,180	3,456	1,156	2,388
92	3,248	3,729	4,294	3,549	1,187	2,452
93	3,334	3,828	4,408	3,643	1,219	2,518
94	3,421	3,930	4,524	3,740	1,251	2,583
95	3,511	4,033	4,645	3,838	1,283	2,651
96	3,603	4,138	4,762	3,936	1,317	2,719
97	3,693	4,240	4,884	4,038	1,350	2,789
98	3,787	4,348	5,008	4,139	1,384	2,859
99+	3,882	4,457	5,134	4,241	1,419	2,930

The above rates do not include the $20 one-time policy fee.

To calculate a 7% Household discount:

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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: Rest of State
Male rates
Rates effective 4/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,616	1,856	2,139	1,766	591	1,155
66	1,616	1,856	2,139	1,766	591	1,155
67	1,616	1,856	2,139	1,766	591	1,155
68	1,634	1,877	2,161	1,785	597	1,195
69	1,672	1,919	2,210	1,826	611	1,245
70	1,716	1,970	2,267	1,876	627	1,293
71	1,768	2,031	2,336	1,932	646	1,338
72	1,823	2,093	2,410	1,991	666	1,383
73	1,881	2,160	2,487	2,055	688	1,429
74	1,948	2,238	2,576	2,129	712	1,478
75	2,016	2,314	2,666	2,203	737	1,526
76	2,086	2,397	2,760	2,280	762	1,574
77	2,160	2,481	2,855	2,361	790	1,627
78	2,232	2,565	2,953	2,441	817	1,682
79	2,303	2,644	3,045	2,517	842	1,735
80	2,377	2,728	3,140	2,597	868	1,794
81	2,451	2,814	3,242	2,677	896	1,850
82	2,523	2,898	3,336	2,758	922	1,904
83	2,601	2,987	3,440	2,843	951	1,965
84	2,677	3,076	3,540	2,924	979	2,021
85	2,775	3,187	3,667	3,033	1,014	2,094
86	2,853	3,278	3,773	3,119	1,043	2,155
87	2,935	3,371	3,879	3,209	1,073	2,217
88	3,018	3,465	3,989	3,297	1,103	2,277
89	3,100	3,562	4,101	3,389	1,134	2,342
90	3,187	3,658	4,211	3,481	1,165	2,406
91	3,273	3,759	4,327	3,575	1,196	2,472
92	3,360	3,858	4,445	3,671	1,228	2,538
93	3,450	3,962	4,562	3,771	1,262	2,606
94	3,541	4,066	4,684	3,871	1,295	2,673
95	3,634	4,173	4,806	3,972	1,328	2,743
96	3,729	4,281	4,930	4,074	1,363	2,814
97	3,824	4,390	5,055	4,178	1,397	2,886
98	3,919	4,502	5,183	4,284	1,433	2,959
99+	4,019	4,613	5,312	4,391	1,469	3,033

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,795	2,063	2,374	1,962	657	1,283
66	1,795	2,063	2,374	1,962	657	1,283
67	1,795	2,063	2,374	1,962	657	1,283
68	1,816	2,085	2,400	1,985	664	1,328
69	1,856	2,134	2,455	2,030	679	1,383
70	1,907	2,188	2,521	2,083	697	1,436
71	1,964	2,256	2,597	2,146	718	1,486
72	2,024	2,325	2,680	2,214	739	1,537
73	2,091	2,400	2,765	2,283	764	1,587
74	2,167	2,485	2,861	2,366	791	1,642
75	2,241	2,573	2,962	2,448	819	1,695
76	2,320	2,661	3,065	2,533	848	1,749
77	2,400	2,757	3,173	2,624	877	1,808
78	2,481	2,850	3,280	2,712	907	1,869
79	2,560	2,939	3,384	2,797	935	1,928
80	2,640	3,031	3,491	2,885	965	1,993
81	2,722	3,128	3,602	2,976	996	2,056
82	2,804	3,219	3,708	3,062	1,025	2,115
83	2,891	3,319	3,820	3,158	1,057	2,182
84	2,975	3,416	3,932	3,250	1,088	2,246
85	3,082	3,540	4,074	3,368	1,127	2,327
86	3,172	3,643	4,192	3,466	1,159	2,394
87	3,261	3,744	4,313	3,565	1,193	2,462
88	3,352	3,850	4,430	3,664	1,226	2,532
89	3,444	3,957	4,554	3,763	1,260	2,602
90	3,540	4,065	4,678	3,869	1,295	2,672
91	3,635	4,177	4,808	3,973	1,329	2,746
92	3,735	4,287	4,938	4,081	1,365	2,819
93	3,834	4,402	5,070	4,189	1,402	2,895
94	3,935	4,518	5,204	4,301	1,439	2,970
95	4,039	4,637	5,341	4,413	1,475	3,048
96	4,145	4,758	5,476	4,526	1,515	3,127
97	4,247	4,877	5,617	4,644	1,553	3,207
98	4,356	5,000	5,758	4,760	1,592	3,288
99+	4,463	5,126	5,903	4,878	1,632	3,370

The above rates do not include the $20 one-time policy fee.

To calculate a 7% 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. Other policies may be provided with Issue Age rating and do not increase with age. You should compare Issue Age with Attained Age policies.

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

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

HOUSEHOLD DISCOUNT

In order to be eligible for the Household discount under an Aetna Health 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 have a Medicare supplement policy with an Aetna company. The Medicare eligible adult must be either (a) your spouse or someone with whom you are in a civil union partnership; and (b) someone with whom you have continuously resided for the past 12 months. The household discount will only be applicable if a policy for each applicant is issued. The discounted rates will be 7 percent lower than the individual rates and will apply as long as both policies remain in force.

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to 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 $1,632	$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
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 $204 a day	$0	Up to $204 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 $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
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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $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
HOSPITALIZATION* 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
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 $204 a day	$0	Up to $204 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 $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
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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $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
HOSPITALIZATION* 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
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 $204 a day	Up to $204 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 $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
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 $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$240 (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 $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

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 $1,632	$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
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 $204 a day	Up to $204 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 $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
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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $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

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 $2,800 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
HOSPITALIZATION* 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
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 $204 a day	Up to $204 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 $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
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 $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
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
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
CLINICAL LABORATORY SERVICES – 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
HOME HEALTH CARE – 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 (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
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 $1,632	$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
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 $204 a day	Up to $204 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 $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
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 $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.
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
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
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 $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
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