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: 03/2021 A

AETNA HEALTH NSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE
BENEFIT PLANS AVILABLE: 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 2021[2]					**$6,220[2]**	**$3,110[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2370 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 3/1/2021

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,122	1,288	1,524	1,260	560	930
66	1,122	1,288	1,524	1,260	560	930
67	1,122	1,288	1,524	1,260	560	930
68	1,134	1,301	1,541	1,273	566	962
69	1,160	1,332	1,576	1,303	579	1,003
70	1,190	1,367	1,618	1,337	594	1,041
71	1,226	1,408	1,667	1,378	613	1,077
72	1,264	1,452	1,719	1,420	631	1,114
73	1,305	1,499	1,775	1,466	652	1,151
74	1,352	1,552	1,837	1,518	675	1,190
75	1,398	1,606	1,901	1,572	699	1,228
76	1,448	1,662	1,967	1,626	723	1,268
77	1,499	1,721	2,037	1,684	749	1,310
78	1,549	1,779	2,106	1,741	774	1,355
79	1,598	1,834	2,172	1,795	798	1,397
80	1,648	1,892	2,240	1,852	823	1,444
81	1,700	1,952	2,312	1,910	849	1,490
82	1,751	2,010	2,379	1,966	874	1,534
83	1,805	2,072	2,453	2,027	901	1,582
84	1,857	2,133	2,524	2,086	928	1,627
85	1,925	2,211	2,616	2,163	961	1,686
86	1,979	2,274	2,690	2,225	989	1,735
87	2,036	2,338	2,768	2,288	1,017	1,784
88	2,093	2,403	2,845	2,351	1,045	1,834
89	2,151	2,470	2,924	2,417	1,075	1,886
90	2,211	2,538	3,004	2,483	1,104	1,937
91	2,270	2,607	3,087	2,551	1,134	1,990
92	2,332	2,677	3,170	2,619	1,164	2,044
93	2,394	2,749	3,255	2,689	1,196	2,098
94	2,457	2,821	3,340	2,761	1,227	2,153
95	2,521	2,895	3,428	2,833	1,259	2,209
96	2,587	2,970	3,515	2,906	1,292	2,266
97	2,652	3,045	3,606	2,980	1,324	2,324
98	2,720	3,123	3,697	3,055	1,358	2,383
99+	2,787	3,200	3,789	3,132	1,392	2,443

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,246	1,431	1,693	1,400	622	1,033
66	1,246	1,431	1,693	1,400	622	1,033
67	1,246	1,431	1,693	1,400	622	1,033
68	1,260	1,446	1,712	1,415	629	1,069
69	1,288	1,480	1,753	1,448	643	1,114
70	1,322	1,518	1,797	1,486	661	1,156
71	1,363	1,565	1,852	1,530	680	1,197
72	1,405	1,613	1,910	1,578	701	1,238
73	1,450	1,666	1,971	1,628	724	1,279
74	1,502	1,724	2,042	1,687	750	1,322
75	1,554	1,784	2,112	1,746	776	1,365
76	1,609	1,846	2,187	1,807	803	1,408
77	1,666	1,912	2,264	1,872	832	1,456
78	1,721	1,976	2,339	1,934	860	1,505
79	1,776	2,038	2,413	1,995	886	1,552
80	1,831	2,103	2,490	2,058	915	1,604
81	1,889	2,169	2,568	2,122	944	1,656
82	1,945	2,233	2,644	2,184	971	1,704
83	2,006	2,302	2,725	2,253	1,002	1,757
84	2,063	2,370	2,805	2,318	1,031	1,808
85	2,139	2,456	2,906	2,402	1,068	1,874
86	2,200	2,527	2,990	2,472	1,099	1,928
87	2,263	2,597	3,075	2,542	1,130	1,983
88	2,325	2,671	3,161	2,613	1,162	2,038
89	2,389	2,745	3,248	2,685	1,195	2,095
90	2,456	2,820	3,338	2,759	1,227	2,152
91	2,522	2,897	3,429	2,834	1,260	2,212
92	2,591	2,975	3,522	2,910	1,294	2,270
93	2,660	3,054	3,616	2,988	1,329	2,332
94	2,729	3,135	3,711	3,067	1,364	2,391
95	2,801	3,217	3,810	3,148	1,398	2,455
96	2,874	3,301	3,905	3,229	1,436	2,518
97	2,946	3,383	4,006	3,311	1,472	2,582
98	3,021	3,469	4,107	3,394	1,509	2,648
99+	3,097	3,556	4,211	3,479	1,547	2,714

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

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 Period, use Preferred rates.

Aetna Health Insurance Company

Annual Premiums

For Use in ZIP Codes: 294-295, 298-299

Male Rates

Rates Effective 3/1/2021

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,289	1,481	1,754	1,449	644	1,069
66	1,289	1,481	1,754	1,449	644	1,069
67	1,289	1,481	1,754	1,449	644	1,069
68	1,304	1,497	1,772	1,464	651	1,106
69	1,334	1,531	1,814	1,498	666	1,153
70	1,369	1,572	1,860	1,538	683	1,197
71	1,410	1,620	1,916	1,585	704	1,238
72	1,454	1,670	1,977	1,633	726	1,281
73	1,501	1,723	2,040	1,686	750	1,323
74	1,554	1,785	2,112	1,746	776	1,369
75	1,608	1,846	2,187	1,807	803	1,413
76	1,664	1,912	2,264	1,870	831	1,457
77	1,723	1,979	2,342	1,937	861	1,506
78	1,781	2,046	2,422	2,002	891	1,558
79	1,838	2,109	2,498	2,064	918	1,607
80	1,896	2,176	2,576	2,130	946	1,661
81	1,955	2,245	2,659	2,196	977	1,713
82	2,013	2,312	2,736	2,262	1,005	1,764
83	2,075	2,383	2,821	2,332	1,037	1,819
84	2,136	2,454	2,904	2,399	1,067	1,872
85	2,214	2,542	3,008	2,487	1,105	1,939
86	2,276	2,615	3,095	2,558	1,137	1,996
87	2,341	2,689	3,182	2,631	1,170	2,052
88	2,407	2,764	3,272	2,704	1,202	2,109
89	2,473	2,841	3,364	2,780	1,236	2,169
90	2,542	2,918	3,454	2,856	1,270	2,228
91	2,611	2,999	3,549	2,933	1,304	2,289
92	2,681	3,078	3,646	3,012	1,339	2,350
93	2,752	3,161	3,742	3,092	1,376	2,413
94	2,825	3,244	3,841	3,175	1,412	2,475
95	2,899	3,329	3,941	3,258	1,448	2,541
96	2,975	3,416	4,043	3,342	1,486	2,606
97	3,050	3,502	4,146	3,427	1,523	2,673
98	3,127	3,592	4,251	3,513	1,562	2,740
99+	3,206	3,680	4,357	3,601	1,601	2,809

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,432	1,646	1,947	1,610	716	1,188
66	1,432	1,646	1,947	1,610	716	1,188
67	1,432	1,646	1,947	1,610	716	1,188
68	1,449	1,663	1,969	1,627	724	1,230
69	1,481	1,703	2,014	1,664	740	1,281
70	1,521	1,746	2,068	1,708	760	1,330
71	1,567	1,800	2,130	1,760	783	1,377
72	1,615	1,855	2,197	1,815	806	1,424
73	1,668	1,915	2,267	1,873	833	1,470
74	1,728	1,983	2,347	1,940	862	1,521
75	1,788	2,052	2,430	2,008	893	1,570
76	1,850	2,123	2,515	2,079	924	1,620
77	1,915	2,199	2,603	2,153	956	1,674
78	1,979	2,273	2,690	2,224	989	1,731
79	2,042	2,345	2,776	2,294	1,019	1,785
80	2,106	2,418	2,863	2,366	1,052	1,845
81	2,172	2,495	2,954	2,441	1,086	1,904
82	2,237	2,568	3,041	2,512	1,117	1,959
83	2,306	2,648	3,134	2,591	1,152	2,021
84	2,373	2,725	3,225	2,666	1,186	2,080
85	2,459	2,824	3,342	2,763	1,228	2,155
86	2,530	2,906	3,438	2,843	1,263	2,217
87	2,602	2,987	3,537	2,923	1,300	2,280
88	2,674	3,072	3,634	3,005	1,336	2,345
89	2,748	3,157	3,735	3,087	1,373	2,409
90	2,824	3,243	3,838	3,173	1,412	2,474
91	2,900	3,332	3,944	3,259	1,449	2,543
92	2,980	3,420	4,050	3,347	1,488	2,611
93	3,059	3,512	4,158	3,436	1,528	2,681
94	3,139	3,605	4,268	3,527	1,569	2,750
95	3,222	3,699	4,381	3,620	1,608	2,823
96	3,306	3,795	4,492	3,713	1,651	2,896
97	3,388	3,891	4,606	3,808	1,693	2,969
98	3,475	3,989	4,723	3,903	1,735	3,044
99+	3,561	4,089	4,842	4,001	1,779	3,122

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

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 Period, use Preferred rates.

Aetna Health Insurance Company

Annual Premiums

For Use in: Rest of State

Female Rates

Rates Effective 3/1/2021

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,029	1,182	1,398	1,156	514	853
66	1,029	1,182	1,398	1,156	514	853
67	1,029	1,182	1,398	1,156	514	853
68	1,040	1,194	1,414	1,168	519	883
69	1,064	1,222	1,446	1,195	531	920
70	1,092	1,254	1,484	1,227	545	955
71	1,125	1,292	1,529	1,264	562	988
72	1,160	1,332	1,577	1,303	579	1,022
73	1,197	1,375	1,628	1,345	598	1,056
74	1,240	1,424	1,685	1,393	619	1,092
75	1,283	1,473	1,744	1,442	641	1,127
76	1,328	1,525	1,805	1,492	663	1,163
77	1,375	1,579	1,869	1,545	687	1,202
78	1,421	1,632	1,932	1,597	710	1,243
79	1,466	1,683	1,993	1,647	732	1,282
80	1,512	1,736	2,055	1,699	755	1,325
81	1,560	1,791	2,121	1,752	779	1,367
82	1,606	1,844	2,183	1,804	802	1,407
83	1,656	1,901	2,250	1,860	827	1,451
84	1,704	1,957	2,316	1,914	851	1,493
85	1,766	2,028	2,400	1,984	882	1,547
86	1,816	2,086	2,468	2,041	907	1,592
87	1,868	2,145	2,539	2,099	933	1,637
88	1,920	2,205	2,610	2,157	959	1,683
89	1,973	2,266	2,683	2,217	986	1,730
90	2,028	2,328	2,756	2,278	1,013	1,777
91	2,083	2,392	2,832	2,340	1,040	1,826
92	2,139	2,456	2,908	2,403	1,068	1,875
93	2,196	2,522	2,986	2,467	1,097	1,925
94	2,254	2,588	3,064	2,533	1,126	1,975
95	2,313	2,656	3,145	2,599	1,155	2,027
96	2,373	2,725	3,225	2,666	1,185	2,079
97	2,433	2,794	3,308	2,734	1,215	2,132
98	2,495	2,865	3,392	2,803	1,246	2,186
99+	2,557	2,936	3,476	2,873	1,277	2,241

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,143	1,313	1,553	1,284	571	948
66	1,143	1,313	1,553	1,284	571	948
67	1,143	1,313	1,553	1,284	571	948
68	1,156	1,327	1,571	1,298	577	981
69	1,182	1,358	1,608	1,328	590	1,022
70	1,213	1,393	1,649	1,363	606	1,061
71	1,250	1,436	1,699	1,404	624	1,098
72	1,289	1,480	1,752	1,448	643	1,136
73	1,330	1,528	1,808	1,494	664	1,173
74	1,378	1,582	1,873	1,548	688	1,213
75	1,426	1,637	1,938	1,602	712	1,252
76	1,476	1,694	2,006	1,658	737	1,292
77	1,528	1,754	2,077	1,717	763	1,336
78	1,579	1,813	2,146	1,774	789	1,381
79	1,629	1,870	2,214	1,830	813	1,424
80	1,680	1,929	2,284	1,888	839	1,472
81	1,733	1,990	2,356	1,947	866	1,519
82	1,784	2,049	2,426	2,004	891	1,563
83	1,840	2,112	2,500	2,067	919	1,612
84	1,893	2,174	2,573	2,127	946	1,659
85	1,962	2,253	2,666	2,204	980	1,719
86	2,018	2,318	2,743	2,268	1,008	1,769
87	2,076	2,383	2,821	2,332	1,037	1,819
88	2,133	2,450	2,900	2,397	1,066	1,870
89	2,192	2,518	2,980	2,463	1,096	1,922
90	2,253	2,587	3,062	2,531	1,126	1,974
91	2,314	2,658	3,146	2,600	1,156	2,029
92	2,377	2,729	3,231	2,670	1,187	2,083
93	2,440	2,802	3,317	2,741	1,219	2,139
94	2,504	2,876	3,405	2,814	1,251	2,194
95	2,570	2,951	3,495	2,888	1,283	2,252
96	2,637	3,028	3,583	2,962	1,317	2,310
97	2,703	3,104	3,675	3,038	1,350	2,369
98	2,772	3,183	3,768	3,114	1,384	2,429
99+	2,841	3,262	3,863	3,192	1,419	2,490

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

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 Period, use Preferred rates.

Aetna Health Insurance Company

Annual Premiums
For Use in: Rest of State
Male Rates

Rates Effective 3/1/2021

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,183	1,359	1,609	1,329	591	981
66	1,183	1,359	1,609	1,329	591	981
67	1,183	1,359	1,609	1,329	591	981
68	1,196	1,373	1,626	1,343	597	1,015
69	1,224	1,405	1,664	1,374	611	1,058
70	1,256	1,442	1,706	1,411	627	1,098
71	1,294	1,486	1,758	1,454	646	1,136
72	1,334	1,532	1,814	1,498	666	1,175
73	1,377	1,581	1,872	1,547	688	1,214
74	1,426	1,638	1,938	1,602	712	1,256
75	1,475	1,694	2,006	1,658	737	1,296
76	1,527	1,754	2,077	1,716	762	1,337
77	1,581	1,816	2,149	1,777	790	1,382
78	1,634	1,877	2,222	1,837	817	1,429
79	1,686	1,935	2,292	1,894	842	1,474
80	1,739	1,996	2,363	1,954	868	1,524
81	1,794	2,060	2,439	2,015	896	1,572
82	1,847	2,121	2,510	2,075	922	1,618
83	1,904	2,186	2,588	2,139	951	1,669
84	1,960	2,251	2,664	2,201	979	1,717
85	2,031	2,332	2,760	2,282	1,014	1,779
86	2,088	2,399	2,839	2,347	1,043	1,831
87	2,148	2,467	2,919	2,414	1,073	1,883
88	2,208	2,536	3,002	2,481	1,103	1,935
89	2,269	2,606	3,086	2,550	1,134	1,990
90	2,332	2,677	3,169	2,620	1,165	2,044
91	2,395	2,751	3,256	2,691	1,196	2,100
92	2,460	2,824	3,345	2,763	1,228	2,156
93	2,525	2,900	3,433	2,837	1,262	2,214
94	2,592	2,976	3,524	2,913	1,295	2,271
95	2,660	3,054	3,616	2,989	1,328	2,331
96	2,729	3,134	3,709	3,066	1,363	2,391
97	2,798	3,213	3,804	3,144	1,397	2,452
98	2,869	3,295	3,900	3,223	1,433	2,514
99+	2,941	3,376	3,997	3,304	1,469	2,577

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,314	1,510	1,786	1,477	657	1,090
66	1,314	1,510	1,786	1,477	657	1,090
67	1,314	1,510	1,786	1,477	657	1,090
68	1,329	1,526	1,806	1,493	664	1,128
69	1,359	1,562	1,848	1,527	679	1,175
70	1,395	1,602	1,897	1,567	697	1,220
71	1,438	1,651	1,954	1,615	718	1,263
72	1,482	1,702	2,016	1,665	739	1,306
73	1,530	1,757	2,080	1,718	764	1,349
74	1,585	1,819	2,153	1,780	791	1,395
75	1,640	1,883	2,229	1,842	819	1,440
76	1,697	1,948	2,307	1,907	848	1,486
77	1,757	2,017	2,388	1,975	877	1,536
78	1,816	2,085	2,468	2,040	907	1,588
79	1,873	2,151	2,547	2,105	935	1,638
80	1,932	2,218	2,627	2,171	965	1,693
81	1,993	2,289	2,710	2,239	996	1,747
82	2,052	2,356	2,790	2,305	1,025	1,797
83	2,116	2,429	2,875	2,377	1,057	1,854
84	2,177	2,500	2,959	2,446	1,088	1,908
85	2,256	2,591	3,066	2,535	1,127	1,977
86	2,321	2,666	3,154	2,608	1,159	2,034
87	2,387	2,740	3,245	2,682	1,193	2,092
88	2,453	2,818	3,334	2,757	1,226	2,151
89	2,521	2,896	3,427	2,832	1,260	2,210
90	2,591	2,975	3,521	2,911	1,295	2,270
91	2,661	3,057	3,618	2,990	1,329	2,333
92	2,734	3,138	3,716	3,071	1,365	2,395
93	2,806	3,222	3,815	3,152	1,402	2,460
94	2,880	3,307	3,916	3,236	1,439	2,523
95	2,956	3,394	4,019	3,321	1,475	2,590
96	3,033	3,482	4,121	3,406	1,515	2,657
97	3,108	3,570	4,226	3,494	1,553	2,724
98	3,188	3,660	4,333	3,581	1,592	2,793
99+	3,267	3,751	4,442	3,671	1,632	2,864

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

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 Period, use Preferred rates.

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, KY 40512-4770. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do **NOT** cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

The policy may not cover all of your medical costs.

Neither 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 $1,484	$0	$1,484 (Part A Deductible)
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a da	$742 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 $185.50 a day	$0	Up to $185.50 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 $203 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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	$0	Up to $185.50 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 $203 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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 test, durable medical equipment			
First $203 of Medicare-Approved amounts*	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$203 (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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 $203 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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $2370 deductible. Benefits from high deductible plan G will not begin until out-of-pocket expenses are $2370. 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 $2370 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2370 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
*While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $2370 deductible. Benefits from high deductible plan G will not begin until out-of-pocket expenses are $2370. 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 $2370 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2370 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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $2370 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2370 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
*Medically necessary skilled care services and medical supplies	100%	$0	$0
*Durable medical equipment			
First $203 of Medicare Approved amounts	$0	$0	$203 (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 $2370 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2370 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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
*While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ 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 $203 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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 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.
Part B Excess Charges (Above Medicare-Approved amounts)	$0	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts	$0	$0	$203 (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