Outline of coverage

Medicare Supplement Insurance

Benefit plans: A, B, F, G, High Deductible G, N

Iowa

Underwritten by

Aetna Health Insurance Company

aetnaseniorproducts.com

AHCMS04867IA

Rates effective: 07/2019 B

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 2020[2]					**$5,880[2]**	**$2,940[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,340 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

Aetna Health Insurance Company

Annual Premiums

For Use In: Entire State

Female Rates

Rates Effective 7/1/2019

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,027	1,168	1,281	1,104	514	839
66	1,027	1,168	1,281	1,104	514	839
67	1,027	1,168	1,281	1,104	514	839
68	1,038	1,180	1,295	1,116	519	869
69	1,062	1,207	1,324	1,142	531	905
70	1,090	1,239	1,359	1,172	545	939
71	1,123	1,276	1,400	1,207	561	972
72	1,158	1,316	1,444	1,245	579	1,005
73	1,196	1,359	1,491	1,285	598	1,039
74	1,238	1,407	1,543	1,331	619	1,074
75	1,281	1,456	1,597	1,377	640	1,109
76	1,326	1,507	1,653	1,425	663	1,144
77	1,373	1,560	1,712	1,476	686	1,183
78	1,419	1,613	1,770	1,526	710	1,222
79	1,464	1,663	1,825	1,574	732	1,261
80	1,510	1,715	1,882	1,623	755	1,303
81	1,557	1,769	1,942	1,674	778	1,345
82	1,604	1,822	2,000	1,724	802	1,385
83	1,653	1,878	2,061	1,777	826	1,427
84	1,701	1,933	2,121	1,829	851	1,469
85	1,763	2,003	2,198	1,895	881	1,522
86	1,814	2,061	2,261	1,950	907	1,566
87	1,865	2,119	2,325	2,005	932	1,610
88	1,917	2,178	2,391	2,061	959	1,655
89	1,971	2,239	2,457	2,118	985	1,701
90	2,025	2,301	2,524	2,177	1,012	1,748
91	2,080	2,363	2,593	2,236	1,040	1,796
92	2,136	2,427	2,663	2,296	1,068	1,844
93	2,193	2,492	2,734	2,357	1,096	1,893
94	2,251	2,557	2,806	2,419	1,125	1,943
95	2,310	2,624	2,879	2,483	1,155	1,994
96	2,369	2,692	2,954	2,547	1,185	2,046
97	2,430	2,761	3,029	2,612	1,215	2,098
98	2,491	2,831	3,106	2,678	1,245	2,151
99+	2,553	2,901	3,183	2,745	1,277	2,205

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,141	1,298	1,423	1,227	571	932
66	1,141	1,298	1,423	1,227	571	932
67	1,141	1,298	1,423	1,227	571	932
68	1,153	1,311	1,439	1,240	577	966
69	1,180	1,341	1,471	1,269	590	1,006
70	1,211	1,377	1,510	1,302	606	1,043
71	1,248	1,418	1,556	1,341	623	1,080
72	1,287	1,462	1,604	1,383	643	1,117
73	1,329	1,510	1,657	1,428	664	1,154
74	1,376	1,563	1,714	1,479	688	1,193
75	1,423	1,618	1,774	1,530	711	1,232
76	1,473	1,674	1,837	1,583	737	1,271
77	1,526	1,733	1,902	1,640	762	1,314
78	1,577	1,792	1,967	1,696	789	1,358
79	1,627	1,848	2,028	1,749	813	1,401
80	1,678	1,906	2,091	1,803	839	1,448
81	1,730	1,966	2,158	1,860	864	1,494
82	1,782	2,024	2,222	1,916	891	1,539
83	1,837	2,087	2,290	1,974	918	1,586
84	1,890	2,148	2,357	2,032	946	1,632
85	1,959	2,226	2,442	2,106	979	1,691
86	2,016	2,290	2,512	2,167	1,008	1,740
87	2,072	2,354	2,583	2,228	1,036	1,789
88	2,130	2,420	2,657	2,290	1,066	1,839
89	2,190	2,488	2,730	2,353	1,094	1,890
90	2,250	2,557	2,804	2,419	1,124	1,942
91	2,311	2,626	2,881	2,484	1,156	1,996
92	2,373	2,697	2,959	2,551	1,187	2,049
93	2,437	2,769	3,038	2,619	1,218	2,103
94	2,501	2,841	3,118	2,688	1,250	2,159
95	2,567	2,916	3,199	2,759	1,283	2,216
96	2,632	2,991	3,282	2,830	1,317	2,273
97	2,700	3,068	3,366	2,902	1,350	2,331
98	2,768	3,146	3,451	2,976	1,383	2,390
99+	2,837	3,223	3,537	3,050	1,419	2,450

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 Household discount:

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

Modal premium x .93 = discounted premium

Aetna Health Insurance Company

Annual Premiums

For Use In: Entire State

Male Rates

Rates Effective 7/1/2019

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,181	1,343	1,473	1,270	591	965
66	1,181	1,343	1,473	1,270	591	965
67	1,181	1,343	1,473	1,270	591	965
68	1,194	1,357	1,489	1,283	597	999
69	1,221	1,388	1,523	1,313	611	1,041
70	1,254	1,425	1,563	1,348	627	1,080
71	1,291	1,467	1,610	1,388	645	1,118
72	1,332	1,513	1,661	1,432	666	1,156
73	1,375	1,563	1,715	1,478	688	1,195
74	1,424	1,618	1,774	1,531	712	1,235
75	1,473	1,674	1,837	1,584	736	1,275
76	1,525	1,733	1,901	1,639	762	1,316
77	1,579	1,794	1,969	1,697	789	1,360
78	1,632	1,855	2,036	1,755	817	1,405
79	1,684	1,912	2,099	1,810	842	1,450
80	1,737	1,972	2,164	1,866	868	1,498
81	1,791	2,034	2,233	1,925	895	1,547
82	1,845	2,095	2,300	1,983	922	1,593
83	1,901	2,160	2,370	2,044	950	1,641
84	1,956	2,223	2,439	2,103	979	1,689
85	2,027	2,303	2,528	2,179	1,013	1,750
86	2,086	2,370	2,600	2,243	1,043	1,801
87	2,145	2,437	2,674	2,306	1,072	1,852
88	2,205	2,505	2,750	2,370	1,103	1,903
89	2,267	2,575	2,826	2,436	1,133	1,956
90	2,329	2,646	2,903	2,504	1,164	2,010
91	2,392	2,717	2,982	2,571	1,196	2,065
92	2,456	2,791	3,062	2,640	1,228	2,121
93	2,522	2,866	3,144	2,711	1,260	2,177
94	2,589	2,941	3,227	2,782	1,294	2,234
95	2,657	3,018	3,311	2,855	1,328	2,293
96	2,724	3,096	3,397	2,929	1,363	2,353
97	2,795	3,175	3,483	3,004	1,397	2,413
98	2,865	3,256	3,572	3,080	1,432	2,474
99+	2,936	3,336	3,660	3,157	1,469	2,536

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,312	1,493	1,636	1,411	657	1,072
66	1,312	1,493	1,636	1,411	657	1,072
67	1,312	1,493	1,636	1,411	657	1,072
68	1,326	1,508	1,655	1,426	664	1,111
69	1,357	1,542	1,692	1,459	679	1,157
70	1,393	1,584	1,737	1,497	697	1,199
71	1,435	1,631	1,789	1,542	716	1,242
72	1,480	1,681	1,845	1,590	739	1,285
73	1,528	1,737	1,906	1,642	764	1,327
74	1,582	1,797	1,971	1,701	791	1,372
75	1,636	1,861	2,040	1,760	818	1,417
76	1,694	1,925	2,113	1,820	848	1,462
77	1,755	1,993	2,187	1,886	876	1,511
78	1,814	2,061	2,262	1,950	907	1,562
79	1,871	2,125	2,332	2,011	935	1,611
80	1,930	2,192	2,405	2,073	965	1,665
81	1,990	2,261	2,482	2,139	994	1,718
82	2,049	2,328	2,555	2,203	1,025	1,770
83	2,113	2,400	2,634	2,270	1,056	1,824
84	2,174	2,470	2,711	2,337	1,088	1,877
85	2,253	2,560	2,808	2,422	1,126	1,945
86	2,318	2,634	2,889	2,492	1,159	2,001
87	2,383	2,707	2,970	2,562	1,191	2,057
88	2,450	2,783	3,056	2,634	1,226	2,115
89	2,519	2,861	3,140	2,706	1,258	2,174
90	2,588	2,941	3,225	2,782	1,293	2,233
91	2,658	3,020	3,313	2,857	1,329	2,295
92	2,729	3,102	3,403	2,934	1,365	2,356
93	2,803	3,184	3,494	3,012	1,401	2,418
94	2,876	3,267	3,586	3,091	1,438	2,483
95	2,952	3,353	3,679	3,173	1,475	2,548
96	3,027	3,440	3,774	3,255	1,515	2,614
97	3,105	3,528	3,871	3,337	1,553	2,681
98	3,183	3,618	3,969	3,422	1,590	2,749
99+	3,263	3,706	4,068	3,508	1,632	2,818

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 Household discount:

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

Modal premium x .93 = discounted premium

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 $1,408	$0	$1,408 (Part A Deductible)
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	$0	Up to $176 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 $198 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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare Approved amounts*	$0	$0	$198 (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 $1,408	$1,408 (Part A Deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	$0	Up to $176 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 $198 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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare Approved amounts*	$0	$0	$198 (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 $1,408	$1,408 (Part A Deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 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 $198 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 $198 of Medicare-Approved amounts*	$0	$198 (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 $198 of Medicare-Approved amounts*	$0	$198 (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 $198 of Medicare Approved amounts*	$0	$198 (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 $1,408	$1,408 (Part A Deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 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 $198 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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare Approved amounts*	$0	$0	$198 (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 $2,340 deductible. Benefits from high deductible plan G will not begin until out-of-pocket expenses are $2,340. 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 $2,340 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,340 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$1,408 (Part A Deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
*While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 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 $198 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 $2,340 deductible. Benefits from high deductible plan G will not begin until out-of-pocket expenses are $2,340. 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 $2,340 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,340 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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $2,340 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,340 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
*Medically necessary skilled care services and medical supplies	100%	$0	$0
*Durable medical equipment			
First $198 of Medicare Approved amounts	$0	$0	$198 (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 $2,340 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,340 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 $1,408	$1,408 (Part A Deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
*While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 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 $198 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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare Approved amounts*	$0	$0	$198 (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