Outline of coverage

Medicare Supplement Insurance

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

Pennsylvania

Underwritten by

Aetna Health Insurance Company

aetnaseniorproducts.com

AHCMS04874PA

Rates effective: 03/2021A

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. Every company must make available Plans A, B and D or G. 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 $2,370 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: 150-154 and 156
Female Rates

Rates Effective: 03/01/2021

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,342	1,494	1,868	1,496	566	1,098
65	1,342	1,494	1,868	1,496	566	1,098
66	1,342	1,494	1,868	1,496	566	1,098
67	1,342	1,494	1,868	1,496	566	1,098
68	1,357	1,510	1,888	1,512	572	1,137
69	1,388	1,544	1,931	1,547	585	1,185
70	1,426	1,586	1,983	1,588	600	1,231
71	1,469	1,633	2,042	1,635	619	1,273
72	1,515	1,685	2,107	1,686	637	1,317
73	1,564	1,739	2,175	1,741	658	1,360
74	1,618	1,800	2,251	1,802	682	1,408
75	1,676	1,863	2,330	1,865	705	1,452
76	1,734	1,929	2,410	1,931	730	1,498
77	1,795	1,996	2,497	1,999	756	1,549
78	1,856	2,064	2,581	2,067	782	1,601
79	1,914	2,129	2,661	2,131	806	1,653
80	1,973	2,197	2,745	2,199	831	1,708
81	2,036	2,266	2,831	2,268	858	1,761
82	2,096	2,332	2,916	2,336	883	1,814
83	2,161	2,405	3,006	2,407	910	1,870
84	2,224	2,475	3,094	2,477	936	1,924
85	2,305	2,563	3,205	2,568	971	1,994
86	2,371	2,638	3,297	2,642	998	2,050
87	2,438	2,713	3,390	2,716	1,027	2,109
88	2,506	2,788	3,487	2,792	1,056	2,168
89	2,576	2,865	3,583	2,869	1,084	2,229
90	2,646	2,945	3,681	2,949	1,114	2,290
91	2,719	3,025	3,782	3,029	1,145	2,352
92	2,792	3,105	3,884	3,111	1,176	2,415
93	2,867	3,189	3,988	3,194	1,208	2,479
94	2,943	3,273	4,093	3,278	1,240	2,545
95	3,019	3,359	4,199	3,364	1,272	2,612
96	3,098	3,444	4,309	3,450	1,304	2,680
97	3,176	3,533	4,418	3,539	1,337	2,747
98	3,257	3,623	4,530	3,628	1,372	2,818
99+	3,338	3,713	4,644	3,719	1,405	2,888

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,492	1,659	2,076	1,663	629	1,220
65	1,492	1,659	2,076	1,663	629	1,220
66	1,492	1,659	2,076	1,663	629	1,220
67	1,492	1,659	2,076	1,663	629	1,220
68	1,508	1,678	2,098	1,680	635	1,264
69	1,542	1,716	2,146	1,718	651	1,316
70	1,585	1,762	2,202	1,764	667	1,367
71	1,631	1,814	2,269	1,817	688	1,415
72	1,681	1,871	2,340	1,873	708	1,463
73	1,738	1,932	2,417	1,934	731	1,511
74	1,799	2,000	2,500	2,002	758	1,564
75	1,862	2,070	2,589	2,072	783	1,613
76	1,926	2,142	2,680	2,146	812	1,665
77	1,994	2,217	2,774	2,221	840	1,722
78	2,062	2,293	2,868	2,297	869	1,779
79	2,126	2,366	2,957	2,368	896	1,837
80	2,193	2,440	3,050	2,443	923	1,898
81	2,262	2,516	3,146	2,520	953	1,956
82	2,330	2,591	3,241	2,596	981	2,015
83	2,401	2,671	3,340	2,675	1,011	2,078
84	2,471	2,750	3,437	2,752	1,040	2,138
85	2,561	2,849	3,562	2,853	1,079	2,216
86	2,635	2,930	3,664	2,935	1,109	2,278
87	2,708	3,014	3,767	3,018	1,141	2,344
88	2,784	3,097	3,874	3,103	1,173	2,408
89	2,861	3,183	3,981	3,188	1,205	2,476
90	2,941	3,272	4,089	3,276	1,239	2,544
91	3,021	3,360	4,202	3,366	1,273	2,613
92	3,103	3,450	4,315	3,457	1,308	2,683
93	3,184	3,543	4,431	3,549	1,342	2,755
94	3,269	3,637	4,547	3,642	1,378	2,828
95	3,355	3,733	4,667	3,738	1,413	2,901
96	3,442	3,828	4,786	3,833	1,449	2,977
97	3,528	3,925	4,908	3,932	1,486	3,052
98	3,618	4,024	5,032	4,032	1,525	3,130
99+	3,710	4,126	5,159	4,132	1,562	3,209

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

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Aetna Health Insurance Company

Annual Premiums

For Use in ZIP Codes: 150-154 and 156

Male Rates

Rates Effective: 03/01/2021

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,543	1,718	2,148	1,720	651	1,263
65	1,543	1,718	2,148	1,720	651	1,263
66	1,543	1,718	2,148	1,720	651	1,263
67	1,543	1,718	2,148	1,720	651	1,263
68	1,562	1,737	2,171	1,739	658	1,308
69	1,597	1,777	2,221	1,779	673	1,363
70	1,640	1,824	2,279	1,826	690	1,416
71	1,688	1,878	2,348	1,880	712	1,464
72	1,741	1,937	2,422	1,939	733	1,515
73	1,799	2,000	2,501	2,002	757	1,564
74	1,861	2,070	2,589	2,072	784	1,619
75	1,926	2,142	2,680	2,145	811	1,670
76	1,993	2,217	2,773	2,221	840	1,723
77	2,064	2,297	2,872	2,299	869	1,781
78	2,133	2,374	2,968	2,377	899	1,841
79	2,201	2,447	3,060	2,451	927	1,901
80	2,269	2,525	3,157	2,529	956	1,964
81	2,341	2,605	3,257	2,608	987	2,025
82	2,410	2,682	3,353	2,686	1,015	2,086
83	2,485	2,765	3,457	2,768	1,047	2,151
84	2,559	2,846	3,558	2,849	1,076	2,213
85	2,651	2,949	3,686	2,953	1,117	2,293
86	2,727	3,033	3,792	3,038	1,148	2,358
87	2,804	3,120	3,900	3,123	1,181	2,425
88	2,883	3,205	4,009	3,211	1,214	2,493
89	2,962	3,295	4,120	3,299	1,247	2,563
90	3,044	3,387	4,234	3,391	1,281	2,634
91	3,126	3,478	4,349	3,483	1,317	2,705
92	3,211	3,571	4,467	3,578	1,352	2,777
93	3,296	3,667	4,586	3,673	1,389	2,851
94	3,383	3,765	4,706	3,770	1,426	2,927
95	3,473	3,863	4,829	3,869	1,463	3,004
96	3,562	3,961	4,954	3,968	1,500	3,082
97	3,652	4,062	5,081	4,070	1,538	3,159
98	3,744	4,164	5,210	4,172	1,578	3,241
99+	3,839	4,271	5,341	4,277	1,616	3,321

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,715	1,908	2,387	1,912	723	1,403
65	1,715	1,908	2,387	1,912	723	1,403
66	1,715	1,908	2,387	1,912	723	1,403
67	1,715	1,908	2,387	1,912	723	1,403
68	1,734	1,931	2,412	1,932	730	1,454
69	1,773	1,973	2,468	1,976	749	1,513
70	1,822	2,026	2,532	2,029	767	1,572
71	1,876	2,086	2,609	2,090	791	1,627
72	1,934	2,152	2,691	2,154	814	1,682
73	1,999	2,221	2,780	2,224	841	1,738
74	2,068	2,300	2,875	2,302	872	1,799
75	2,141	2,381	2,977	2,383	900	1,855
76	2,216	2,463	3,081	2,468	934	1,915
77	2,294	2,550	3,189	2,554	966	1,980
78	2,371	2,638	3,297	2,642	999	2,046
79	2,446	2,720	3,401	2,723	1,030	2,113
80	2,522	2,807	3,508	2,809	1,061	2,183
81	2,601	2,893	3,618	2,898	1,096	2,249
82	2,680	2,981	3,726	2,985	1,128	2,317
83	2,761	3,072	3,840	3,076	1,163	2,390
84	2,843	3,163	3,954	3,165	1,196	2,459
85	2,945	3,275	4,096	3,281	1,241	2,548
86	3,029	3,370	4,214	3,375	1,275	2,620
87	3,115	3,466	4,332	3,471	1,312	2,696
88	3,202	3,562	4,455	3,568	1,349	2,769
89	3,291	3,660	4,579	3,666	1,386	2,847
90	3,382	3,763	4,704	3,767	1,425	2,926
91	3,474	3,864	4,831	3,871	1,464	3,005
92	3,568	3,969	4,962	3,976	1,504	3,085
93	3,663	4,076	5,096	4,081	1,543	3,168
94	3,759	4,183	5,229	4,188	1,585	3,252
95	3,857	4,292	5,367	4,299	1,625	3,336
96	3,958	4,401	5,505	4,408	1,666	3,424
97	4,057	4,515	5,645	4,522	1,709	3,510
98	4,161	4,628	5,788	4,637	1,754	3,600
99+	4,267	4,746	5,933	4,752	1,796	3,690

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

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Aetna Health Insurance Company

Annual Premiums

For Use in ZIP Codes: 189-194

Female Rates

Rates Effective: 03/01/2021

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,447	1,611	2,014	1,613	610	1,184
65	1,447	1,611	2,014	1,613	610	1,184
66	1,447	1,611	2,014	1,613	610	1,184
67	1,447	1,611	2,014	1,613	610	1,184
68	1,463	1,628	2,036	1,631	616	1,226
69	1,497	1,665	2,082	1,668	631	1,277
70	1,538	1,710	2,138	1,712	647	1,327
71	1,583	1,761	2,202	1,763	667	1,373
72	1,633	1,817	2,272	1,818	687	1,420
73	1,686	1,875	2,345	1,877	709	1,467
74	1,745	1,941	2,427	1,943	735	1,518
75	1,807	2,009	2,512	2,011	760	1,566
76	1,870	2,079	2,599	2,082	787	1,616
77	1,936	2,153	2,692	2,155	815	1,670
78	2,001	2,226	2,783	2,228	843	1,726
79	2,063	2,295	2,869	2,298	869	1,782
80	2,128	2,368	2,960	2,371	897	1,841
81	2,195	2,443	3,053	2,445	925	1,898
82	2,261	2,515	3,145	2,518	952	1,955
83	2,330	2,593	3,241	2,595	981	2,016
84	2,398	2,668	3,336	2,671	1,009	2,075
85	2,485	2,764	3,456	2,769	1,047	2,150
86	2,557	2,845	3,555	2,848	1,076	2,211
87	2,629	2,925	3,656	2,929	1,107	2,274
88	2,702	3,006	3,760	3,011	1,138	2,337
89	2,778	3,089	3,864	3,094	1,169	2,403
90	2,853	3,176	3,969	3,179	1,202	2,469
91	2,931	3,261	4,078	3,266	1,235	2,536
92	3,011	3,348	4,187	3,354	1,269	2,604
93	3,091	3,439	4,300	3,443	1,302	2,673
94	3,173	3,529	4,413	3,534	1,337	2,744
95	3,255	3,622	4,527	3,627	1,371	2,816
96	3,341	3,714	4,646	3,720	1,406	2,889
97	3,425	3,809	4,764	3,815	1,442	2,962
98	3,512	3,906	4,884	3,912	1,479	3,038
99+	3,600	4,004	5,007	4,010	1,515	3,114

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,608	1,789	2,238	1,793	678	1,316
65	1,608	1,789	2,238	1,793	678	1,316
66	1,608	1,789	2,238	1,793	678	1,316
67	1,608	1,789	2,238	1,793	678	1,316
68	1,626	1,809	2,262	1,812	684	1,363
69	1,663	1,850	2,314	1,853	702	1,419
70	1,709	1,900	2,375	1,902	719	1,474
71	1,758	1,955	2,447	1,959	742	1,525
72	1,813	2,017	2,523	2,020	764	1,577
73	1,874	2,083	2,606	2,086	789	1,629
74	1,939	2,156	2,696	2,159	817	1,686
75	2,008	2,232	2,791	2,234	844	1,740
76	2,077	2,310	2,889	2,314	875	1,796
77	2,150	2,391	2,991	2,394	905	1,856
78	2,223	2,473	3,093	2,476	937	1,918
79	2,293	2,551	3,188	2,553	966	1,980
80	2,365	2,631	3,288	2,634	996	2,046
81	2,439	2,713	3,393	2,717	1,028	2,109
82	2,512	2,794	3,494	2,799	1,058	2,172
83	2,589	2,881	3,601	2,884	1,090	2,241
84	2,665	2,965	3,706	2,967	1,121	2,305
85	2,761	3,071	3,840	3,076	1,163	2,389
86	2,841	3,160	3,951	3,164	1,195	2,456
87	2,920	3,250	4,062	3,254	1,230	2,527
88	3,002	3,339	4,178	3,346	1,265	2,597
89	3,085	3,432	4,293	3,437	1,300	2,670
90	3,171	3,528	4,409	3,533	1,335	2,743
91	3,257	3,623	4,531	3,629	1,373	2,817
92	3,346	3,720	4,652	3,727	1,410	2,893
93	3,434	3,820	4,778	3,827	1,447	2,971
94	3,525	3,922	4,903	3,927	1,486	3,049
95	3,617	4,025	5,032	4,030	1,524	3,129
96	3,711	4,128	5,161	4,133	1,562	3,210
97	3,804	4,232	5,292	4,240	1,602	3,291
98	3,901	4,339	5,426	4,347	1,644	3,375
99+	4,000	4,449	5,563	4,455	1,684	3,460

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

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Aetna Health Insurance Company

Annual Premiums

For Use in ZIP Codes: 189-194

Male Rates

Rates Effective: 03/01/2021

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,664	1,853	2,316	1,855	702	1,362
65	1,664	1,853	2,316	1,855	702	1,362
66	1,664	1,853	2,316	1,855	702	1,362
67	1,664	1,853	2,316	1,855	702	1,362
68	1,684	1,872	2,341	1,875	709	1,410
69	1,722	1,916	2,394	1,918	725	1,469
70	1,768	1,967	2,458	1,969	744	1,526
71	1,820	2,025	2,532	2,027	768	1,579
72	1,877	2,088	2,611	2,091	790	1,633
73	1,939	2,156	2,697	2,159	816	1,686
74	2,006	2,232	2,791	2,234	846	1,746
75	2,077	2,310	2,889	2,313	874	1,800
76	2,149	2,391	2,990	2,394	905	1,858
77	2,226	2,476	3,096	2,479	937	1,921
78	2,300	2,559	3,200	2,563	970	1,985
79	2,373	2,639	3,300	2,642	999	2,050
80	2,447	2,723	3,404	2,727	1,030	2,118
81	2,525	2,809	3,512	2,812	1,064	2,184
82	2,599	2,892	3,616	2,897	1,095	2,249
83	2,680	2,981	3,727	2,985	1,128	2,319
84	2,759	3,069	3,837	3,071	1,161	2,386
85	2,858	3,179	3,974	3,184	1,204	2,473
86	2,940	3,270	4,088	3,276	1,238	2,542
87	3,023	3,364	4,205	3,368	1,273	2,615
88	3,109	3,456	4,323	3,462	1,309	2,688
89	3,194	3,553	4,443	3,558	1,344	2,764
90	3,282	3,652	4,566	3,657	1,381	2,840
91	3,370	3,750	4,690	3,756	1,420	2,916
92	3,462	3,850	4,816	3,858	1,458	2,995
93	3,554	3,954	4,945	3,961	1,498	3,074
94	3,648	4,060	5,074	4,065	1,538	3,156
95	3,745	4,165	5,207	4,171	1,577	3,239
96	3,840	4,271	5,342	4,278	1,617	3,323
97	3,938	4,380	5,478	4,388	1,658	3,406
98	4,037	4,490	5,617	4,499	1,701	3,494
99+	4,139	4,605	5,759	4,612	1,742	3,581

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,849	2,057	2,574	2,062	780	1,513
65	1,849	2,057	2,574	2,062	780	1,513
66	1,849	2,057	2,574	2,062	780	1,513
67	1,849	2,057	2,574	2,062	780	1,513
68	1,870	2,082	2,600	2,083	787	1,567
69	1,912	2,128	2,661	2,130	807	1,632
70	1,964	2,185	2,730	2,187	827	1,695
71	2,022	2,249	2,814	2,253	853	1,755
72	2,086	2,320	2,902	2,323	878	1,814
73	2,155	2,394	2,997	2,398	906	1,874
74	2,230	2,480	3,100	2,482	940	1,939
75	2,309	2,567	3,210	2,569	971	2,000
76	2,389	2,656	3,322	2,661	1,007	2,065
77	2,474	2,749	3,439	2,754	1,042	2,135
78	2,557	2,845	3,555	2,848	1,078	2,206
79	2,637	2,933	3,667	2,936	1,111	2,278
80	2,719	3,027	3,782	3,029	1,145	2,354
81	2,805	3,120	3,901	3,125	1,182	2,425
82	2,889	3,214	4,018	3,219	1,216	2,499
83	2,977	3,312	4,140	3,317	1,254	2,577
84	3,065	3,410	4,263	3,412	1,290	2,651
85	3,176	3,532	4,417	3,538	1,338	2,748
86	3,266	3,633	4,543	3,639	1,375	2,825
87	3,359	3,737	4,671	3,742	1,415	2,907
88	3,452	3,840	4,804	3,848	1,455	2,986
89	3,549	3,947	4,938	3,953	1,494	3,070
90	3,647	4,057	5,072	4,062	1,536	3,155
91	3,746	4,166	5,209	4,174	1,579	3,240
92	3,848	4,279	5,351	4,287	1,622	3,327
93	3,949	4,395	5,494	4,401	1,664	3,416
94	4,054	4,510	5,638	4,516	1,709	3,507
95	4,159	4,628	5,787	4,635	1,752	3,597
96	4,268	4,745	5,936	4,753	1,797	3,691
97	4,375	4,868	6,087	4,876	1,843	3,784
98	4,486	4,990	6,241	5,000	1,891	3,881
99+	4,600	5,117	6,397	5,124	1,937	3,979

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

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: 03/01/2021

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,167	1,299	1,624	1,301	492	955
65	1,167	1,299	1,624	1,301	492	955
66	1,167	1,299	1,624	1,301	492	955
67	1,167	1,299	1,624	1,301	492	955
68	1,180	1,313	1,642	1,315	497	989
69	1,207	1,343	1,679	1,345	509	1,030
70	1,240	1,379	1,724	1,381	522	1,070
71	1,277	1,420	1,776	1,422	538	1,107
72	1,317	1,465	1,832	1,466	554	1,145
73	1,360	1,512	1,891	1,514	572	1,183
74	1,407	1,565	1,957	1,567	593	1,224
75	1,457	1,620	2,026	1,622	613	1,263
76	1,508	1,677	2,096	1,679	635	1,303
77	1,561	1,736	2,171	1,738	657	1,347
78	1,614	1,795	2,244	1,797	680	1,392
79	1,664	1,851	2,314	1,853	701	1,437
80	1,716	1,910	2,387	1,912	723	1,485
81	1,770	1,970	2,462	1,972	746	1,531
82	1,823	2,028	2,536	2,031	768	1,577
83	1,879	2,091	2,614	2,093	791	1,626
84	1,934	2,152	2,690	2,154	814	1,673
85	2,004	2,229	2,787	2,233	844	1,734
86	2,062	2,294	2,867	2,297	868	1,783
87	2,120	2,359	2,948	2,362	893	1,834
88	2,179	2,424	3,032	2,428	918	1,885
89	2,240	2,491	3,116	2,495	943	1,938
90	2,301	2,561	3,201	2,564	969	1,991
91	2,364	2,630	3,289	2,634	996	2,045
92	2,428	2,700	3,377	2,705	1,023	2,100
93	2,493	2,773	3,468	2,777	1,050	2,156
94	2,559	2,846	3,559	2,850	1,078	2,213
95	2,625	2,921	3,651	2,925	1,106	2,271
96	2,694	2,995	3,747	3,000	1,134	2,330
97	2,762	3,072	3,842	3,077	1,163	2,389
98	2,832	3,150	3,939	3,155	1,193	2,450
99+	2,903	3,229	4,038	3,234	1,222	2,511

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,297	1,443	1,805	1,446	547	1,061
65	1,297	1,443	1,805	1,446	547	1,061
66	1,297	1,443	1,805	1,446	547	1,061
67	1,297	1,443	1,805	1,446	547	1,061
68	1,311	1,459	1,824	1,461	552	1,099
69	1,341	1,492	1,866	1,494	566	1,144
70	1,378	1,532	1,915	1,534	580	1,189
71	1,418	1,577	1,973	1,580	598	1,230
72	1,462	1,627	2,035	1,629	616	1,272
73	1,511	1,680	2,102	1,682	636	1,314
74	1,564	1,739	2,174	1,741	659	1,360
75	1,619	1,800	2,251	1,802	681	1,403
76	1,675	1,863	2,330	1,866	706	1,448
77	1,734	1,928	2,412	1,931	730	1,497
78	1,793	1,994	2,494	1,997	756	1,547
79	1,849	2,057	2,571	2,059	779	1,597
80	1,907	2,122	2,652	2,124	803	1,650
81	1,967	2,188	2,736	2,191	829	1,701
82	2,026	2,253	2,818	2,257	853	1,752
83	2,088	2,323	2,904	2,326	879	1,807
84	2,149	2,391	2,989	2,393	904	1,859
85	2,227	2,477	3,097	2,481	938	1,927
86	2,291	2,548	3,186	2,552	964	1,981
87	2,355	2,621	3,276	2,624	992	2,038
88	2,421	2,693	3,369	2,698	1,020	2,094
89	2,488	2,768	3,462	2,772	1,048	2,153
90	2,557	2,845	3,556	2,849	1,077	2,212
91	2,627	2,922	3,654	2,927	1,107	2,272
92	2,698	3,000	3,752	3,006	1,137	2,333
93	2,769	3,081	3,853	3,086	1,167	2,396
94	2,843	3,163	3,954	3,167	1,198	2,459
95	2,917	3,246	4,058	3,250	1,229	2,523
96	2,993	3,329	4,162	3,333	1,260	2,589
97	3,068	3,413	4,268	3,419	1,292	2,654
98	3,146	3,499	4,376	3,506	1,326	2,722
99+	3,226	3,588	4,486	3,593	1,358	2,790

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

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: 03/01/2021

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,342	1,494	1,868	1,496	566	1,098
65	1,342	1,494	1,868	1,496	566	1,098
66	1,342	1,494	1,868	1,496	566	1,098
67	1,342	1,494	1,868	1,496	566	1,098
68	1,358	1,510	1,888	1,512	572	1,137
69	1,389	1,545	1,931	1,547	585	1,185
70	1,426	1,586	1,982	1,588	600	1,231
71	1,468	1,633	2,042	1,635	619	1,273
72	1,514	1,684	2,106	1,686	637	1,317
73	1,564	1,739	2,175	1,741	658	1,360
74	1,618	1,800	2,251	1,802	682	1,408
75	1,675	1,863	2,330	1,865	705	1,452
76	1,733	1,928	2,411	1,931	730	1,498
77	1,795	1,997	2,497	1,999	756	1,549
78	1,855	2,064	2,581	2,067	782	1,601
79	1,914	2,128	2,661	2,131	806	1,653
80	1,973	2,196	2,745	2,199	831	1,708
81	2,036	2,265	2,832	2,268	858	1,761
82	2,096	2,332	2,916	2,336	883	1,814
83	2,161	2,404	3,006	2,407	910	1,870
84	2,225	2,475	3,094	2,477	936	1,924
85	2,305	2,564	3,205	2,568	971	1,994
86	2,371	2,637	3,297	2,642	998	2,050
87	2,438	2,713	3,391	2,716	1,027	2,109
88	2,507	2,787	3,486	2,792	1,056	2,168
89	2,576	2,865	3,583	2,869	1,084	2,229
90	2,647	2,945	3,682	2,949	1,114	2,290
91	2,718	3,024	3,782	3,029	1,145	2,352
92	2,792	3,105	3,884	3,111	1,176	2,415
93	2,866	3,189	3,988	3,194	1,208	2,479
94	2,942	3,274	4,092	3,278	1,240	2,545
95	3,020	3,359	4,199	3,364	1,272	2,612
96	3,097	3,444	4,308	3,450	1,304	2,680
97	3,176	3,532	4,418	3,539	1,337	2,747
98	3,256	3,621	4,530	3,628	1,372	2,818
99+	3,338	3,714	4,644	3,719	1,405	2,888

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,491	1,659	2,076	1,663	629	1,220
65	1,491	1,659	2,076	1,663	629	1,220
66	1,491	1,659	2,076	1,663	629	1,220
67	1,491	1,659	2,076	1,663	629	1,220
68	1,508	1,679	2,097	1,680	635	1,264
69	1,542	1,716	2,146	1,718	651	1,316
70	1,584	1,762	2,202	1,764	667	1,367
71	1,631	1,814	2,269	1,817	688	1,415
72	1,682	1,871	2,340	1,873	708	1,463
73	1,738	1,931	2,417	1,934	731	1,511
74	1,798	2,000	2,500	2,002	758	1,564
75	1,862	2,070	2,589	2,072	783	1,613
76	1,927	2,142	2,679	2,146	812	1,665
77	1,995	2,217	2,773	2,221	840	1,722
78	2,062	2,294	2,867	2,297	869	1,779
79	2,127	2,365	2,957	2,368	896	1,837
80	2,193	2,441	3,050	2,443	923	1,898
81	2,262	2,516	3,146	2,520	953	1,956
82	2,330	2,592	3,240	2,596	981	2,015
83	2,401	2,671	3,339	2,675	1,011	2,078
84	2,472	2,750	3,438	2,752	1,040	2,138
85	2,561	2,848	3,562	2,853	1,079	2,216
86	2,634	2,930	3,664	2,935	1,109	2,278
87	2,709	3,014	3,767	3,018	1,141	2,344
88	2,784	3,097	3,874	3,103	1,173	2,408
89	2,862	3,183	3,982	3,188	1,205	2,476
90	2,941	3,272	4,090	3,276	1,239	2,544
91	3,021	3,360	4,201	3,366	1,273	2,613
92	3,103	3,451	4,315	3,457	1,308	2,683
93	3,185	3,544	4,431	3,549	1,342	2,755
94	3,269	3,637	4,547	3,642	1,378	2,828
95	3,354	3,732	4,667	3,738	1,413	2,901
96	3,442	3,827	4,787	3,833	1,449	2,977
97	3,528	3,926	4,909	3,932	1,486	3,052
98	3,618	4,024	5,033	4,032	1,525	3,130
99+	3,710	4,127	5,159	4,132	1,562	3,209

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

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 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 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 $2,370 deductible. Benefits from high deductible plan G will not begin until out-of-pocket expenses are $2,370. 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 $2,370 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,370 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 $2,370 deductible. Benefits from high deductible plan G will not begin until out-of-pocket expenses are $2,370. 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 $2,370 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,370 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 $2,370 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,370 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 $2,370 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,370 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