Outline of coverage

Medicare Supplement Insurance

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

New Hampshire

Underwritten by

Aetna Health and Life Insurance Company

aetnaseniorproducts.com

AHLMS05042NH

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Rates effective: 01/2021 A

AETNA HEALTH AND LIFE INSURANCE COMPANY
SUPPLEMENT COVERAGE COVER PAGE: BENEFIT
PLANS AVAILABLE: A, B, F, HF, 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 $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 and Life Insurance Company

Annual Premiums
For Use in Entire State
Female Rates

Rates Effective 01/1/2021

Issue Age	Preferred					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	3,235	3,536	4,708	1,196	3,522	2,995
65	1,616	1,765	2,350	597	1,758	1,469
66	1,628	1,779	2,369	602	1,772	1,486
67	1,658	1,810	2,413	613	1,804	1,522
68	1,690	1,847	2,459	625	1,839	1,560
69	1,730	1,890	2,517	640	1,883	1,603
70	1,771	1,935	2,579	655	1,928	1,644
71	1,819	1,987	2,646	673	1,980	1,687
72	1,865	2,038	2,715	690	2,030	1,730
73	1,912	2,089	2,782	707	2,081	1,772
74	1,959	2,141	2,850	725	2,134	1,814
75	2,011	2,197	2,926	744	2,189	1,861
76	2,060	2,251	2,998	762	2,243	1,905
77	2,112	2,308	3,073	781	2,299	1,953
78	2,162	2,362	3,147	800	2,354	2,000
79	2,213	2,418	3,221	818	2,410	2,047
80	2,265	2,474	3,295	837	2,465	2,095
81	2,318	2,532	3,372	857	2,522	2,144
82	2,370	2,590	3,450	877	2,581	2,194
83	2,425	2,649	3,529	896	2,640	2,245
84	2,481	2,711	3,610	917	2,701	2,296
85	2,544	2,780	3,703	941	2,770	2,355
86	2,598	2,839	3,781	961	2,829	2,404
87	2,652	2,899	3,862	981	2,888	2,455
88	2,708	2,959	3,942	1,002	2,948	2,506
89	2,764	3,021	4,023	1,022	3,009	2,558
90	2,820	3,081	4,105	1,043	3,069	2,610
91	2,876	3,143	4,185	1,064	3,131	2,662
92	2,932	3,204	4,267	1,085	3,192	2,715
93	2,987	3,265	4,347	1,104	3,252	2,765
94	3,041	3,323	4,427	1,125	3,312	2,815
95	3,094	3,380	4,503	1,144	3,368	2,863
96	3,142	3,433	4,572	1,162	3,420	2,908
97	3,184	3,479	4,634	1,177	3,466	2,947
98	3,217	3,514	4,680	1,190	3,501	2,977
99+	3,235	3,536	4,708	1,196	3,522	2,995

Issue Age	Standard					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	3,594	3,929	5,231	1,329	3,914	3,328
65	1,795	1,961	2,612	664	1,954	1,633
66	1,808	1,976	2,633	669	1,969	1,651
67	1,842	2,012	2,680	680	2,004	1,691
68	1,878	2,052	2,733	695	2,044	1,733
69	1,921	2,101	2,797	710	2,092	1,780
70	1,968	2,150	2,864	728	2,143	1,826
71	2,021	2,209	2,940	748	2,200	1,874
72	2,074	2,265	3,015	766	2,256	1,923
73	2,124	2,322	3,091	786	2,312	1,969
74	2,177	2,379	3,168	805	2,370	2,015
75	2,235	2,441	3,252	826	2,432	2,067
76	2,290	2,501	3,331	847	2,492	2,116
77	2,348	2,564	3,415	867	2,555	2,170
78	2,403	2,624	3,497	888	2,615	2,222
79	2,459	2,687	3,579	909	2,677	2,274
80	2,516	2,750	3,662	930	2,738	2,328
81	2,575	2,812	3,747	953	2,802	2,383
82	2,633	2,877	3,833	974	2,868	2,437
83	2,695	2,944	3,920	996	2,933	2,494
84	2,756	3,011	4,010	1,019	3,001	2,551
85	2,827	3,089	4,115	1,046	3,078	2,616
86	2,887	3,155	4,202	1,068	3,143	2,672
87	2,947	3,222	4,291	1,090	3,208	2,727
88	3,009	3,289	4,380	1,113	3,275	2,784
89	3,070	3,357	4,470	1,136	3,343	2,842
90	3,134	3,424	4,560	1,159	3,410	2,900
91	3,197	3,492	4,650	1,182	3,479	2,957
92	3,258	3,561	4,741	1,205	3,546	3,015
93	3,320	3,628	4,831	1,227	3,613	3,072
94	3,379	3,694	4,919	1,250	3,680	3,128
95	3,438	3,756	5,003	1,271	3,743	3,181
96	3,491	3,816	5,081	1,291	3,800	3,230
97	3,538	3,865	5,149	1,308	3,850	3,274
98	3,574	3,905	5,200	1,322	3,891	3,307
99+	3,594	3,929	5,231	1,329	3,914	3,328

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 and Life Insurance Company

Annual Premiums
For Use in Entire State
Male Rates

Rates Effective 01/1/2021

Issue	Preferred					
Age	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	3,720	4,066	5,415	1,376	4,051	3,444
65	1,858	2,029	2,703	686	2,022	1,690
66	1,872	2,047	2,724	693	2,037	1,709
67	1,906	2,082	2,775	704	2,075	1,749
68	1,944	2,124	2,829	719	2,115	1,793
69	1,989	2,173	2,894	735	2,166	1,843
70	2,038	2,225	2,966	754	2,218	1,891
71	2,091	2,284	3,043	774	2,277	1,940
72	2,145	2,343	3,121	792	2,335	1,990
73	2,198	2,403	3,199	813	2,394	2,037
74	2,253	2,462	3,278	834	2,454	2,087
75	2,312	2,526	3,366	855	2,517	2,140
76	2,368	2,589	3,448	877	2,579	2,191
77	2,430	2,655	3,534	899	2,644	2,246
78	2,487	2,716	3,619	919	2,706	2,301
79	2,546	2,781	3,703	941	2,771	2,354
80	2,604	2,845	3,789	963	2,834	2,410
81	2,664	2,912	3,878	986	2,900	2,466
82	2,726	2,979	3,968	1,008	2,968	2,523
83	2,789	3,048	4,059	1,031	3,036	2,582
84	2,853	3,117	4,152	1,055	3,106	2,640
85	2,926	3,197	4,259	1,083	3,184	2,707
86	2,987	3,265	4,348	1,106	3,253	2,765
87	3,051	3,334	4,442	1,127	3,320	2,823
88	3,115	3,403	4,533	1,151	3,390	2,883
89	3,178	3,473	4,626	1,175	3,460	2,943
90	3,244	3,542	4,720	1,199	3,530	3,001
91	3,308	3,615	4,813	1,223	3,599	3,061
92	3,373	3,685	4,907	1,247	3,670	3,121
93	3,435	3,755	5,000	1,270	3,739	3,180
94	3,498	3,822	5,091	1,294	3,808	3,238
95	3,559	3,888	5,178	1,316	3,873	3,292
96	3,614	3,950	5,258	1,336	3,932	3,344
97	3,661	4,000	5,330	1,354	3,985	3,389
98	3,700	4,041	5,382	1,369	4,026	3,423
99+	3,720	4,066	5,415	1,376	4,051	3,444

Issue	Standard					
Age	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	4,133	4,519	6,016	1,529	4,501	3,827
65	2,065	2,255	3,003	763	2,247	1,877
66	2,080	2,273	3,028	769	2,263	1,899
67	2,118	2,313	3,083	782	2,305	1,944
68	2,160	2,360	3,143	799	2,352	1,994
69	2,211	2,416	3,216	816	2,405	2,048
70	2,264	2,472	3,293	837	2,465	2,099
71	2,324	2,539	3,381	860	2,531	2,155
72	2,385	2,604	3,469	882	2,594	2,211
73	2,443	2,670	3,556	904	2,660	2,263
74	2,503	2,736	3,643	926	2,726	2,318
75	2,568	2,807	3,739	950	2,798	2,378
76	2,633	2,876	3,831	973	2,865	2,433
77	2,700	2,948	3,927	997	2,938	2,496
78	2,763	3,020	4,021	1,021	3,008	2,556
79	2,827	3,090	4,115	1,045	3,079	2,614
80	2,893	3,162	4,210	1,069	3,149	2,677
81	2,960	3,235	4,309	1,095	3,223	2,739
82	3,028	3,309	4,407	1,121	3,299	2,803
83	3,099	3,386	4,508	1,146	3,373	2,868
84	3,170	3,462	4,613	1,172	3,452	2,933
85	3,252	3,553	4,733	1,203	3,540	3,009
86	3,320	3,628	4,832	1,228	3,614	3,072
87	3,390	3,704	4,934	1,253	3,689	3,137
88	3,460	3,782	5,036	1,280	3,765	3,201
89	3,532	3,859	5,141	1,306	3,845	3,268
90	3,604	3,937	5,245	1,332	3,922	3,335
91	3,676	4,015	5,348	1,360	4,001	3,402
92	3,747	4,095	5,453	1,386	4,079	3,469
93	3,818	4,173	5,555	1,411	4,155	3,533
94	3,886	4,247	5,656	1,437	4,232	3,597
95	3,954	4,320	5,753	1,461	4,304	3,659
96	4,014	4,388	5,843	1,484	4,369	3,715
97	4,069	4,444	5,921	1,505	4,428	3,764
98	4,109	4,492	5,980	1,520	4,474	3,804
99+	4,133	4,519	6,016	1,529	4,501	3,827

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 and Life Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state. 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 a Aetna Health and Life 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 be covered by an Aetna Company Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (b) someone with whom you are in a civil union partnership; and (c) 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 rate 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 and Life 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 and Life 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 have made material misrepresentations in your application.

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, HIGH DEDUCTIBLE F, G and N OFFERED BY AETNA HEALTH AND LIFE 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 $1484	$0	$1484 (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 test, 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 $1484	$1484 (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 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 test, 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 $1484	$1484 (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 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

HIGH DEDUCTIBLE 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.

****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2370 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2370. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do 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 $1484	$1484 (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 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 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.

****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2370 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2370. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do 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 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

HIGH DEDUCTIBLE PLAN F

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	$203 (Part B Deductible)	$0
•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 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 $1484	$1484 (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 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 test, 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

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 $1484	$1484 (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 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 test, 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 copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-Approved amounts)	$0	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $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