

**AETNA HEALTH AND LIFE INSURANCE COMPANY**  
**OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 2**  
**BENEFIT PLANS AVAILABLE: A, B, F, HIGH DEDUCTIBLE F, G, N**

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A" and "B" and "C" or "F". Some plans may not be available in your state.

**See Outlines of Coverage sections for details about ALL PLANS**

**Basic Benefits:**

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-Approved expenses) or, copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of coinsurance or copayments

Blood: First three pints of blood each year.

Hospice-Part A coinsurance

<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>F/F*</b>	<b>G</b>	<b>K</b>	<b>L</b>	<b>M</b>	<b>N</b>
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
	Part B Deductible	Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit \$4960; paid at 100% after limit reached	Out-of-pocket limit \$2480; paid at 100% after limit reached		

\*Plans F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2180. 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.

**Aetna Health and Life Insurance Company**

Annual Attained Age Premiums

For Use in ZIP Codes: 150-154, 156

Female Rates

Rates Effective 5/1/2016

Attained Age	Preferred					Standard				
	Plan A	Plan B	Plan F	Plan HF	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan N
0 - 64	1,312	1,395	1,797	718	1,440	1,458	1,550	1,997	798	1,599
65	1,312	1,395	1,797	718	1,440	1,458	1,550	1,997	798	1,599
66	1,312	1,395	1,797	718	1,440	1,458	1,550	1,997	798	1,599
67	1,312	1,395	1,797	718	1,440	1,458	1,550	1,997	798	1,599
68	1,366	1,453	1,872	749	1,500	1,518	1,615	2,080	832	1,668
69	1,427	1,518	1,944	778	1,569	1,585	1,687	2,160	864	1,741
70	1,484	1,580	2,014	805	1,630	1,649	1,753	2,239	895	1,811
71	1,540	1,638	2,086	834	1,692	1,712	1,819	2,318	927	1,880
72	1,594	1,695	2,152	861	1,750	1,771	1,884	2,390	955	1,945
73	1,647	1,749	2,210	884	1,807	1,827	1,944	2,454	981	2,006
74	1,691	1,799	2,267	908	1,859	1,880	1,999	2,520	1,008	2,064
75	1,735	1,844	2,318	927	1,904	1,926	2,049	2,575	1,030	2,116
76	1,774	1,887	2,364	945	1,948	1,971	2,098	2,628	1,051	2,164
77	1,813	1,927	2,407	961	1,990	2,012	2,142	2,674	1,067	2,211
78	1,848	1,965	2,443	976	2,030	2,052	2,184	2,714	1,086	2,253
79	1,880	1,998	2,477	991	2,065	2,087	2,221	2,752	1,100	2,291
80	1,911	2,032	2,507	1,003	2,098	2,120	2,257	2,787	1,113	2,330
81	1,937	2,060	2,540	1,018	2,130	2,152	2,290	2,823	1,129	2,364
82	1,964	2,088	2,572	1,030	2,157	2,180	2,320	2,858	1,143	2,394
83	1,990	2,116	2,603	1,042	2,185	2,207	2,351	2,892	1,156	2,426
84	2,013	2,142	2,632	1,055	2,212	2,234	2,379	2,924	1,170	2,454
85	2,038	2,166	2,661	1,065	2,237	2,262	2,408	2,957	1,183	2,484
86	2,061	2,190	2,688	1,077	2,262	2,287	2,433	2,988	1,196	2,509
87	2,083	2,214	2,718	1,087	2,288	2,310	2,460	3,021	1,208	2,537
88	2,105	2,237	2,742	1,096	2,311	2,335	2,486	3,046	1,218	2,563
89	2,124	2,258	2,765	1,106	2,332	2,356	2,508	3,071	1,229	2,586
90	2,143	2,277	2,789	1,113	2,353	2,377	2,530	3,099	1,239	2,608
91	2,160	2,297	2,809	1,123	2,373	2,396	2,552	3,124	1,247	2,630
92	2,177	2,313	2,829	1,130	2,390	2,415	2,570	3,144	1,256	2,650
93	2,191	2,330	2,848	1,137	2,408	2,432	2,588	3,165	1,266	2,670
94	2,206	2,344	2,861	1,143	2,424	2,450	2,606	3,179	1,271	2,687
95	2,219	2,357	2,878	1,150	2,438	2,463	2,619	3,198	1,277	2,702
96	2,231	2,372	2,892	1,155	2,451	2,476	2,635	3,213	1,285	2,717
97	2,245	2,386	2,906	1,161	2,467	2,494	2,651	3,230	1,290	2,735
98	2,258	2,401	2,922	1,168	2,482	2,506	2,666	3,246	1,297	2,749
99	2,272	2,415	2,936	1,174	2,495	2,521	2,681	3,260	1,304	2,765
Modal Factors:	Semi-Annual: 0.5200					Quarterly: 0.2650				
					Monthly: 0.08330					

The above rates do not include the \$20 application 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 Attained Age Premiums

For Use in ZIP Codes: 150-154, 156

Male Rates

Rates Effective 5/1/2016

Attained Age	Preferred					Standard				
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan A	Plan B	Plan F	Plan HF	Plan G
0 - 64	1,509	1,604	2,067	826	1,656	1,675	1,782	2,296	917	1,840
65	1,509	1,604	2,067	826	1,656	1,675	1,782	2,296	917	1,840
66	1,509	1,604	2,067	826	1,656	1,675	1,782	2,296	917	1,840
67	1,509	1,604	2,067	826	1,656	1,675	1,782	2,296	917	1,840
68	1,572	1,671	2,153	861	1,726	1,746	1,857	2,391	955	1,917
69	1,643	1,747	2,236	894	1,803	1,825	1,939	2,485	993	2,002
70	1,708	1,817	2,318	927	1,874	1,896	2,016	2,574	1,029	2,082
71	1,773	1,885	2,397	959	1,945	1,969	2,094	2,665	1,064	2,160
72	1,835	1,951	2,475	990	2,014	2,037	2,166	2,749	1,098	2,236
73	1,893	2,013	2,541	1,018	2,077	2,102	2,236	2,824	1,129	2,309
74	1,948	2,070	2,608	1,042	2,135	2,160	2,300	2,897	1,157	2,373
75	1,998	2,121	2,668	1,065	2,190	2,217	2,357	2,962	1,183	2,432
76	2,043	2,170	2,719	1,087	2,240	2,268	2,412	3,022	1,207	2,489
77	2,087	2,218	2,765	1,107	2,288	2,317	2,464	3,073	1,229	2,543
78	2,126	2,261	2,808	1,123	2,332	2,362	2,510	3,122	1,246	2,592
79	2,163	2,299	2,849	1,139	2,373	2,402	2,554	3,166	1,266	2,638
80	2,199	2,336	2,883	1,154	2,410	2,441	2,595	3,204	1,280	2,681
81	2,231	2,371	2,921	1,168	2,446	2,476	2,633	3,245	1,297	2,719
82	2,261	2,402	2,958	1,181	2,478	2,508	2,669	3,287	1,315	2,756
83	2,290	2,433	2,993	1,198	2,509	2,541	2,703	3,325	1,330	2,792
84	2,318	2,464	3,028	1,211	2,542	2,572	2,735	3,364	1,346	2,825
85	2,345	2,493	3,061	1,224	2,572	2,604	2,768	3,400	1,360	2,859
86	2,371	2,520	3,092	1,238	2,600	2,631	2,797	3,436	1,374	2,891
87	2,396	2,547	3,125	1,250	2,627	2,659	2,828	3,474	1,388	2,921
88	2,422	2,573	3,152	1,262	2,655	2,687	2,857	3,504	1,400	2,954
89	2,445	2,596	3,180	1,273	2,680	2,713	2,883	3,533	1,412	2,980
90	2,466	2,618	3,208	1,285	2,702	2,736	2,908	3,563	1,425	3,006
91	2,487	2,641	3,234	1,294	2,725	2,760	2,934	3,593	1,437	3,032
92	2,505	2,660	3,253	1,301	2,746	2,780	2,955	3,616	1,444	3,053
93	2,523	2,681	3,276	1,310	2,765	2,800	2,977	3,639	1,455	3,075
94	2,540	2,697	3,290	1,317	2,784	2,819	2,995	3,656	1,463	3,095
95	2,555	2,713	3,309	1,324	2,801	2,834	3,012	3,676	1,470	3,113
96	2,569	2,728	3,325	1,331	2,817	2,850	3,027	3,695	1,477	3,131
97	2,586	2,746	3,341	1,337	2,835	2,869	3,047	3,713	1,485	3,150
98	2,600	2,761	3,361	1,346	2,851	2,884	3,064	3,733	1,494	3,168
99	2,616	2,778	3,375	1,352	2,868	2,901	3,082	3,750	1,500	3,188
Modal Factors:	Semi-Annual: 0.5200					Quarterly: 0.2650				
						Monthly: 0.08330				

The above rates do not include the \$20 application 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 Attained Age Premiums

For Use in ZIP Codes: 189-194

Female Rates

Rates Effective 5/1/2016

Attained Age	Preferred					Standard				
	Plan A	Plan B	Plan F	Plan HF	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan N
0 - 64	1,432	1,522	1,961	784	1,571	1,590	1,691	2,178	870	1,745
65	1,432	1,522	1,961	784	1,571	1,590	1,691	2,178	870	1,745
66	1,432	1,522	1,961	784	1,571	1,590	1,691	2,178	870	1,745
67	1,432	1,522	1,961	784	1,571	1,590	1,691	2,178	870	1,745
68	1,490	1,585	2,042	817	1,637	1,656	1,762	2,269	907	1,819
69	1,556	1,656	2,120	848	1,711	1,729	1,841	2,357	942	1,900
70	1,619	1,723	2,197	878	1,778	1,799	1,913	2,442	977	1,975
71	1,680	1,787	2,275	910	1,846	1,867	1,985	2,528	1,012	2,051
72	1,739	1,849	2,347	940	1,909	1,932	2,056	2,608	1,042	2,122
73	1,796	1,908	2,411	965	1,972	1,993	2,120	2,677	1,070	2,189
74	1,844	1,962	2,473	990	2,028	2,051	2,180	2,749	1,099	2,251
75	1,892	2,011	2,528	1,012	2,077	2,101	2,236	2,809	1,123	2,309
76	1,936	2,058	2,579	1,031	2,125	2,150	2,288	2,867	1,146	2,360
77	1,978	2,102	2,626	1,049	2,171	2,195	2,336	2,917	1,164	2,412
78	2,016	2,143	2,665	1,064	2,214	2,238	2,382	2,960	1,184	2,458
79	2,051	2,179	2,702	1,081	2,252	2,276	2,423	3,002	1,200	2,500
80	2,084	2,216	2,735	1,094	2,288	2,312	2,462	3,041	1,214	2,542
81	2,113	2,248	2,771	1,110	2,323	2,347	2,498	3,079	1,231	2,579
82	2,142	2,278	2,806	1,123	2,353	2,378	2,531	3,118	1,247	2,611
83	2,171	2,309	2,839	1,136	2,383	2,407	2,564	3,155	1,261	2,646
84	2,196	2,336	2,872	1,151	2,413	2,437	2,596	3,190	1,277	2,677
85	2,224	2,363	2,903	1,162	2,441	2,467	2,627	3,226	1,290	2,710
86	2,249	2,389	2,933	1,175	2,467	2,495	2,654	3,259	1,304	2,737
87	2,273	2,416	2,965	1,186	2,496	2,520	2,683	3,295	1,318	2,767
88	2,297	2,441	2,992	1,195	2,521	2,548	2,712	3,323	1,328	2,796
89	2,317	2,464	3,017	1,206	2,544	2,570	2,736	3,350	1,340	2,821
90	2,338	2,484	3,042	1,214	2,567	2,593	2,760	3,380	1,351	2,845
91	2,357	2,506	3,065	1,225	2,588	2,614	2,784	3,408	1,361	2,869
92	2,375	2,524	3,086	1,232	2,608	2,634	2,803	3,430	1,370	2,891
93	2,390	2,542	3,107	1,241	2,627	2,653	2,824	3,452	1,381	2,912
94	2,406	2,557	3,121	1,247	2,645	2,672	2,843	3,468	1,386	2,932
95	2,420	2,572	3,139	1,254	2,659	2,687	2,857	3,488	1,393	2,947
96	2,434	2,587	3,155	1,260	2,674	2,701	2,874	3,505	1,402	2,964
97	2,449	2,603	3,170	1,266	2,692	2,720	2,892	3,523	1,408	2,983
98	2,464	2,620	3,187	1,274	2,707	2,734	2,909	3,541	1,415	2,999
99	2,478	2,634	3,203	1,280	2,722	2,750	2,924	3,557	1,422	3,017
Modal Factors:	Semi-Annual:					Monthly:				
	0.5200					0.08330				

Quarterly: 0.2650

The above rates do not include the \$20 application 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 Attained Age Premiums

For Use in ZIP Codes: 189-194

Male Rates

Rates Effective 5/1/2016

Attained Age	Preferred					Standard				
	Plan A	Plan B	Plan F	Plan HF	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan N
0 - 64	1,646	1,750	2,255	901	1,806	1,828	1,944	2,504	1,001	2,008
65	1,646	1,750	2,255	901	1,806	1,828	1,944	2,504	1,001	2,008
66	1,646	1,750	2,255	901	1,806	1,828	1,944	2,504	1,001	2,008
67	1,646	1,750	2,255	901	1,806	1,828	1,944	2,504	1,001	2,008
68	1,715	1,823	2,348	940	1,883	1,904	2,026	2,609	1,042	2,092
69	1,793	1,906	2,440	976	1,967	1,991	2,116	2,711	1,084	2,184
70	1,864	1,982	2,528	1,012	2,045	2,069	2,200	2,808	1,122	2,272
71	1,934	2,057	2,615	1,046	2,122	2,148	2,285	2,908	1,160	2,357
72	2,002	2,129	2,700	1,080	2,197	2,222	2,363	2,999	1,198	2,440
73	2,065	2,196	2,772	1,110	2,266	2,293	2,440	3,080	1,231	2,519
74	2,125	2,258	2,845	1,136	2,329	2,357	2,509	3,161	1,262	2,588
75	2,179	2,314	2,910	1,162	2,389	2,418	2,572	3,232	1,290	2,653
76	2,228	2,368	2,966	1,186	2,443	2,474	2,632	3,296	1,316	2,716
77	2,276	2,419	3,017	1,207	2,496	2,527	2,688	3,353	1,340	2,774
78	2,320	2,466	3,064	1,225	2,544	2,576	2,738	3,406	1,360	2,827
79	2,359	2,508	3,108	1,242	2,588	2,621	2,786	3,454	1,381	2,878
80	2,399	2,549	3,145	1,259	2,629	2,663	2,831	3,496	1,397	2,924
81	2,434	2,586	3,186	1,274	2,669	2,701	2,873	3,540	1,415	2,966
82	2,466	2,621	3,227	1,289	2,704	2,736	2,911	3,586	1,434	3,006
83	2,498	2,654	3,265	1,307	2,737	2,772	2,948	3,628	1,451	3,046
84	2,528	2,688	3,304	1,321	2,773	2,806	2,983	3,670	1,469	3,082
85	2,558	2,719	3,340	1,336	2,806	2,840	3,019	3,709	1,483	3,119
86	2,586	2,749	3,373	1,350	2,837	2,870	3,052	3,749	1,499	3,154
87	2,614	2,778	3,409	1,363	2,866	2,900	3,085	3,790	1,514	3,186
88	2,642	2,807	3,438	1,376	2,897	2,932	3,116	3,822	1,528	3,222
89	2,668	2,832	3,469	1,388	2,923	2,959	3,145	3,854	1,541	3,251
90	2,690	2,856	3,499	1,402	2,947	2,984	3,173	3,887	1,554	3,280
91	2,713	2,881	3,528	1,411	2,972	3,011	3,200	3,919	1,567	3,307
92	2,732	2,902	3,548	1,420	2,995	3,032	3,223	3,944	1,576	3,330
93	2,753	2,924	3,574	1,429	3,017	3,054	3,247	3,970	1,588	3,354
94	2,771	2,942	3,589	1,436	3,037	3,076	3,268	3,989	1,596	3,377
95	2,788	2,959	3,610	1,445	3,055	3,091	3,286	4,010	1,603	3,396
96	2,802	2,976	3,628	1,452	3,073	3,109	3,302	4,031	1,612	3,415
97	2,821	2,995	3,644	1,458	3,092	3,130	3,324	4,050	1,620	3,437
98	2,837	3,012	3,666	1,469	3,110	3,146	3,342	4,073	1,630	3,456
99	2,854	3,030	3,682	1,475	3,128	3,164	3,362	4,091	1,637	3,478
Modal Factors:	Semi-Annual: 0.5200					Monthly: 0.08330				

The above rates do not include the \$20 application 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 Attained Age Premiums

For Use in ZIP Codes: Rest of state

Female Rates

Rates Effective 5/1/2016

Attained Age	Preferred					Standard				
	Plan A	Plan B	Plan F	Plan HF	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan N
0 - 64	1,193	1,268	1,634	653	1,309	1,325	1,409	1,815	725	1,454
65	1,193	1,268	1,634	653	1,309	1,325	1,409	1,815	725	1,454
66	1,193	1,268	1,634	653	1,309	1,325	1,409	1,815	725	1,454
67	1,193	1,268	1,634	653	1,309	1,325	1,409	1,815	725	1,454
68	1,242	1,321	1,702	681	1,364	1,380	1,468	1,891	756	1,516
69	1,297	1,380	1,767	707	1,426	1,441	1,534	1,964	785	1,583
70	1,349	1,436	1,831	732	1,482	1,499	1,594	2,035	814	1,646
71	1,400	1,489	1,896	758	1,538	1,556	1,654	2,107	843	1,709
72	1,449	1,541	1,956	783	1,591	1,610	1,713	2,173	868	1,768
73	1,497	1,590	2,009	804	1,643	1,661	1,767	2,231	892	1,824
74	1,537	1,635	2,061	825	1,690	1,709	1,817	2,291	916	1,876
75	1,577	1,676	2,107	843	1,731	1,751	1,863	2,341	936	1,924
76	1,613	1,715	2,149	859	1,771	1,792	1,907	2,389	955	1,967
77	1,648	1,752	2,188	874	1,809	1,829	1,947	2,431	970	2,010
78	1,680	1,786	2,221	887	1,845	1,865	1,985	2,467	987	2,048
79	1,709	1,816	2,252	901	1,877	1,897	2,019	2,502	1,000	2,083
80	1,737	1,847	2,279	912	1,907	1,927	2,052	2,534	1,012	2,118
81	1,761	1,873	2,309	925	1,936	1,956	2,082	2,566	1,026	2,149
82	1,785	1,898	2,338	936	1,961	1,982	2,109	2,598	1,039	2,176
83	1,809	1,924	2,366	947	1,986	2,006	2,137	2,629	1,051	2,205
84	1,830	1,947	2,393	959	2,011	2,031	2,163	2,658	1,064	2,231
85	1,853	1,969	2,419	968	2,034	2,056	2,189	2,688	1,075	2,258
86	1,874	1,991	2,444	979	2,056	2,079	2,212	2,716	1,087	2,281
87	1,894	2,013	2,471	988	2,080	2,100	2,236	2,746	1,098	2,306
88	1,914	2,034	2,493	996	2,101	2,123	2,260	2,769	1,107	2,330
89	1,931	2,053	2,514	1,005	2,120	2,142	2,280	2,792	1,117	2,351
90	1,948	2,070	2,535	1,012	2,139	2,161	2,300	2,817	1,126	2,371
91	1,964	2,088	2,554	1,021	2,157	2,178	2,320	2,840	1,134	2,391
92	1,979	2,103	2,572	1,027	2,173	2,195	2,336	2,858	1,142	2,409
93	1,992	2,118	2,589	1,034	2,189	2,211	2,353	2,877	1,151	2,427
94	2,005	2,131	2,601	1,039	2,204	2,227	2,369	2,890	1,155	2,443
95	2,017	2,143	2,616	1,045	2,216	2,239	2,381	2,907	1,161	2,456
96	2,028	2,156	2,629	1,050	2,228	2,251	2,395	2,921	1,168	2,470
97	2,041	2,169	2,642	1,055	2,243	2,267	2,410	2,936	1,173	2,486
98	2,053	2,183	2,656	1,062	2,256	2,278	2,424	2,951	1,179	2,499
99	2,065	2,195	2,669	1,067	2,268	2,292	2,437	2,964	1,185	2,514
Modal Factors:					0.5200	Quarterly: 0.2650 Monthly: 0.08330				
Semi-Annual:					0.5200					

The above rates do not include the \$20 application 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 Attained Age Premiums

For Use in ZIP Codes: Rest of state

Male Rates

Rates Effective 5/1/2016

Attained	Preferred					Standard							
	Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64		1,372	1,458	1,879	751	1,505	1,265	1,523	1,620	2,087	834	1,673	1,405
65		1,372	1,458	1,879	751	1,505	1,265	1,523	1,620	2,087	834	1,673	1,405
66		1,372	1,458	1,879	751	1,505	1,265	1,523	1,620	2,087	834	1,673	1,405
67		1,372	1,458	1,879	751	1,505	1,265	1,523	1,620	2,087	834	1,673	1,405
68		1,429	1,519	1,957	783	1,569	1,318	1,587	1,688	2,174	868	1,743	1,464
69		1,494	1,588	2,033	813	1,639	1,377	1,659	1,763	2,259	903	1,820	1,530
70		1,553	1,652	2,107	843	1,704	1,432	1,724	1,833	2,340	935	1,893	1,591
71		1,612	1,714	2,179	872	1,768	1,485	1,790	1,904	2,423	967	1,964	1,651
72		1,668	1,774	2,250	900	1,831	1,537	1,852	1,969	2,499	998	2,033	1,709
73		1,721	1,830	2,310	925	1,888	1,586	1,911	2,033	2,567	1,026	2,099	1,763
74		1,771	1,882	2,371	947	1,941	1,632	1,964	2,091	2,634	1,052	2,157	1,813
75		1,816	1,928	2,425	968	1,991	1,673	2,015	2,143	2,693	1,075	2,211	1,859
76		1,857	1,973	2,472	988	2,036	1,712	2,062	2,193	2,747	1,097	2,263	1,902
77		1,897	2,016	2,514	1,006	2,080	1,748	2,106	2,240	2,794	1,117	2,312	1,943
78		1,933	2,055	2,553	1,021	2,120	1,782	2,147	2,282	2,838	1,133	2,356	1,981
79		1,966	2,090	2,590	1,035	2,157	1,812	2,184	2,322	2,878	1,151	2,398	2,015
80		1,999	2,124	2,621	1,049	2,191	1,842	2,219	2,359	2,913	1,164	2,437	2,047
81		2,028	2,155	2,655	1,062	2,224	1,869	2,251	2,394	2,950	1,179	2,472	2,078
82		2,055	2,184	2,689	1,074	2,253	1,893	2,280	2,426	2,988	1,195	2,505	2,104
83		2,082	2,212	2,721	1,089	2,281	1,918	2,310	2,457	3,023	1,209	2,538	2,132
84		2,107	2,240	2,753	1,101	2,311	1,942	2,338	2,486	3,058	1,224	2,568	2,159
85		2,132	2,266	2,783	1,113	2,338	1,965	2,367	2,516	3,091	1,236	2,599	2,185
86		2,155	2,291	2,811	1,125	2,364	1,987	2,392	2,543	3,124	1,249	2,628	2,208
87		2,178	2,315	2,841	1,136	2,388	2,007	2,417	2,571	3,158	1,262	2,655	2,232
88		2,202	2,339	2,865	1,147	2,414	2,029	2,443	2,597	3,185	1,273	2,685	2,256
89		2,223	2,360	2,891	1,157	2,436	2,048	2,466	2,621	3,212	1,284	2,709	2,276
90		2,242	2,380	2,916	1,168	2,456	2,065	2,487	2,644	3,239	1,295	2,733	2,296
91		2,261	2,401	2,940	1,176	2,477	2,084	2,509	2,667	3,266	1,306	2,756	2,315
92		2,277	2,418	2,957	1,183	2,496	2,099	2,527	2,686	3,287	1,313	2,775	2,332
93		2,294	2,437	2,978	1,191	2,514	2,115	2,545	2,706	3,308	1,323	2,795	2,348
94		2,309	2,452	2,991	1,197	2,531	2,128	2,563	2,723	3,324	1,330	2,814	2,364
95		2,323	2,466	3,008	1,204	2,546	2,140	2,576	2,738	3,342	1,336	2,830	2,377
96		2,335	2,480	3,023	1,210	2,561	2,152	2,591	2,752	3,359	1,343	2,846	2,390
97		2,351	2,496	3,037	1,215	2,577	2,165	2,608	2,770	3,375	1,350	2,864	2,405
98		2,364	2,510	3,055	1,224	2,592	2,177	2,622	2,785	3,394	1,358	2,880	2,417
99		2,378	2,525	3,068	1,229	2,607	2,190	2,637	2,802	3,409	1,364	2,898	2,433
Modal Factors:		Semi-Annual: 0.5200					Monthly: 0.08330					Quarterly: 0.2650	

The above rates do not include the \$20 application 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 for this policy will increase annually 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 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 Health and Life Insurance Company Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (b) be someone with whom you are in a civil union partnership; or (c) be a permanent resident in your home. 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 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, HIGH DEDUCTIBLE F, G and N OFFERED BY AETNA HEALTH AND LIFE INSURANCE COMPANY.**



## PLAN A

### MEDICARE (PART A) – HOSPITAL SERVICES – PER CALENDAR YEAR

\*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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$0  \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$1288 (Part A Deductible) \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0 \$0 \$0	\$0 Up to \$161 a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 \$166 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
<b>MEDICAL EXPENSES –</b> 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 \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$0  Generally 20%	\$166 (Part B Deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0  80%	All costs \$0  20%	\$0 \$166 (Part B Deductible)  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

## PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE –</b> MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies  •Durable medical equipment •First \$166 of Medicare Approved amounts*  •Remainder of Medicare Approved amounts	100%  \$0  80%	\$0  \$0  20%	\$0  \$166 (Part B Deductible)  \$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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1288 (Part A Deductible) \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0 \$0 \$0	\$0  Up to \$161 a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 \$166 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
<b>MEDICAL EXPENSES –</b> 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 \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$0  Generally 20%	\$166 (Part B Deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0  80%	All costs \$0  20%	\$0 \$166 (Part B Deductible)  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

## PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE –</b> MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies  •Durable medical equipment •First \$166 of Medicare Approved amounts*  •Remainder of Medicare Approved amounts	100%  \$0  80%	\$0  \$0  20%	\$0  \$166 (Part B Deductible)  \$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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1288 (Part A Deductible) \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0  Up to \$161 a day \$0	\$0  \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 \$166 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
<b>MEDICAL EXPENSES –</b> 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 \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$166 (Part B Deductible)  Generally 20%	\$0  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0  80%	All costs \$166 (Part B Deductible)  20%	\$0 \$0  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE –</b> MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies  •Durable medical equipment •First \$166 of Medicare Approved amounts*  •Remainder of Medicare Approved amounts	100%  \$0  80%	\$0  \$166 (Part B Deductible)  20%	\$0  \$0  \$0

## PLAN F

### OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

## High Deductible 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 \$2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are \$2180. 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 \$2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2180 DEDUCTIBLE*** YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1288 (Part A Deductible) \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0  Up to \$161 a day \$0	\$0  \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0



<b>HOSPICE CARE</b> 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
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**\*\*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 \$166 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 \$2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are \$2180. 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 \$2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2180 DEDUCTIBLE*** YOU PAY
<b>MEDICAL EXPENSES –</b> 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 \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0        Generally 80%	\$166 (Part B Deductible)        Generally 20%	\$0        \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0   80%	All costs \$166 (Part B Deductible)   20%	\$0 \$0   \$0
<b>CLINICAL LABORATORY            SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

## HIGH DEDUCTIBLE PLAN F

### PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2180 DEDUCTIBLE*** YOU PAY
<b>HOME HEALTH CARE – MEDICARE APPROVED SERVICES</b>			
•Medically necessary skilled care services and medical supplies	100%	\$0	\$0
•Durable medical equipment			
•First \$166 of Medicare Approved amounts*	\$0	\$166 (Part B Deductible)	\$0
•Remainder of Medicare Approved amounts	80%	20%	\$0

### OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2180 DEDUCTIBLE** YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1288 (Part A Deductible) \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0  Up to \$161 a day \$0	\$0  \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 \$166 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
<b>MEDICAL EXPENSES –</b> 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 \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$0  Generally 20%	\$166 (Part B Deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0  80%	All costs \$0  20%	\$0 \$166 (Part B Deductible)  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE –</b> MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies •Durable medical equipment •First \$166 of Medicare Approved amounts* •Remainder of Medicare Approved amounts	100%  \$0  80%	\$0  \$0  20%	\$0  \$166 (Part B Deductible)  \$0

## PLAN G

### OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1288 (Part A Deductible) \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0  Up to \$161 a day \$0	\$0  \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 N

### MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

\*Once you have been billed \$166 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
<b>MEDICAL EXPENSES –</b> 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 \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$0  Balance, other than 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.	\$166 (Part B Deductible) 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.
<b>Part B Excess Charges –</b> (Above Medicare-Approved amounts)	\$0	0%	All costs
<b>BLOOD</b> First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0  80%	All costs \$0  20%	\$0 \$166 (Part B Deductible)  \$0
<b>CLINICAL LABORATORY            SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0



## PLAN N

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE – MEDICARE APPROVED SERVICES</b> <ul style="list-style-type: none"> <li>•Medically necessary skilled care services and medical supplies</li> <li>•Durable medical equipment</li> <li>•First \$166 of Medicare Approved amounts*</li> <li>•Remainder of Medicare Approved amounts</li> </ul>	100%  \$0  80%	\$0  \$0  20%	\$0  \$166 (Part B Deductible)  \$0

### OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year  Remainder of charges	  \$0  \$0	  \$0  80% to a lifetime maximum benefit of \$50,000	  \$250  20% and amounts over the \$50,000 lifetime maximum





