aetna®

Aetna Health and Life Insurance Company

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Outline of Coverage

Medicare Supplement Insurance

BENEFIT PLANS A, B, F, High Deductible F, G, N

Underwritten by

Aetna Health and Life Insurance Company

Colorado

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". Some plans may not be available in your state.

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, co-payments 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

A	B	C	D	F/F*	G	K	L	M	N
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	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 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		

*Plan 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: 800-802

Female Rates

Rates Effective 5/1/2016

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0-64	2,273	2,800	3,346	1,323	3,021	2,305
65	1,356	1,672	2,079	822	1,747	1,332
66	1,356	1,672	2,079	822	1,747	1,332
67	1,356	1,672	2,079	822	1,747	1,332
68	1,412	1,741	2,166	857	1,819	1,388
69	1,475	1,818	2,250	890	1,900	1,450
70	1,535	1,892	2,332	922	1,977	1,508
71	1,593	1,964	2,413	954	2,052	1,564
72	1,648	2,032	2,490	983	2,123	1,619
73	1,701	2,097	2,558	1,011	2,191	1,671
74	1,749	2,156	2,624	1,037	2,253	1,719
75	1,793	2,210	2,683	1,060	2,309	1,762
76	1,836	2,262	2,735	1,081	2,362	1,803
77	1,874	2,310	2,782	1,100	2,412	1,841
78	1,911	2,355	2,824	1,118	2,461	1,878
79	1,943	2,396	2,864	1,134	2,503	1,910
80	1,975	2,434	2,901	1,147	2,543	1,939
81	2,003	2,471	2,938	1,162	2,581	1,968
82	2,030	2,503	2,976	1,177	2,615	1,994
83	2,056	2,536	3,011	1,190	2,650	2,020
84	2,081	2,566	3,047	1,205	2,682	2,045
85	2,107	2,598	3,080	1,218	2,715	2,070
86	2,130	2,626	3,111	1,230	2,743	2,092
87	2,153	2,653	3,145	1,244	2,772	2,115
88	2,176	2,681	3,171	1,255	2,801	2,138
89	2,196	2,706	3,199	1,266	2,826	2,157
90	2,215	2,729	3,226	1,277	2,850	2,176
91	2,234	2,752	3,253	1,287	2,874	2,193
92	2,252	2,773	3,273	1,295	2,895	2,210
93	2,268	2,793	3,295	1,304	2,916	2,225
94	2,284	2,812	3,309	1,309	2,936	2,240
95	2,296	2,827	3,328	1,317	2,952	2,253
96	2,308	2,842	3,345	1,323	2,969	2,265
97	2,323	2,861	3,363	1,329	2,988	2,279
98	2,335	2,877	3,381	1,337	3,004	2,292
99	2,350	2,893	3,396	1,343	3,022	2,306

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0-64	2,526	3,112	3,718	1,470	3,356	2,561
65	1,507	1,857	2,310	913	1,940	1,481
66	1,507	1,857	2,310	913	1,940	1,481
67	1,507	1,857	2,310	913	1,940	1,481
68	1,570	1,935	2,406	952	2,022	1,543
69	1,639	2,021	2,500	989	2,111	1,613
70	1,706	2,102	2,591	1,025	2,196	1,676
71	1,770	2,181	2,682	1,060	2,279	1,740
72	1,830	2,257	2,768	1,095	2,358	1,801
73	1,890	2,330	2,842	1,124	2,434	1,858
74	1,943	2,395	2,916	1,152	2,503	1,911
75	1,992	2,455	2,981	1,178	2,566	1,959
76	2,038	2,511	3,039	1,201	2,627	2,004
77	2,081	2,564	3,091	1,223	2,682	2,047
78	2,122	2,615	3,138	1,241	2,734	2,087
79	2,158	2,660	3,183	1,258	2,781	2,123
80	2,193	2,703	3,223	1,275	2,826	2,157
81	2,226	2,742	3,265	1,290	2,868	2,189
82	2,255	2,779	3,306	1,307	2,906	2,219
83	2,284	2,815	3,345	1,323	2,944	2,248
84	2,311	2,850	3,386	1,339	2,980	2,275
85	2,339	2,885	3,423	1,354	3,016	2,302
86	2,364	2,916	3,456	1,367	3,048	2,328
87	2,389	2,947	3,494	1,383	3,080	2,352
88	2,415	2,979	3,524	1,395	3,113	2,377
89	2,438	3,006	3,554	1,407	3,142	2,399
90	2,459	3,032	3,585	1,419	3,168	2,419
91	2,479	3,057	3,614	1,431	3,194	2,440
92	2,497	3,080	3,636	1,439	3,218	2,457
93	2,515	3,103	3,661	1,449	3,241	2,476
94	2,532	3,123	3,676	1,455	3,263	2,493
95	2,547	3,141	3,698	1,464	3,281	2,506
96	2,561	3,157	3,716	1,472	3,300	2,520
97	2,577	3,178	3,736	1,478	3,322	2,537
98	2,592	3,194	3,758	1,487	3,341	2,551
99	2,608	3,213	3,773	1,494	3,359	2,565

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.08333

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: 800-802

Male Rates

Rates Effective 5/1/2016

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0-64	2,613	3,221	3,848	1,521	3,474	2,651
65	1,560	1,923	2,391	946	2,009	1,532
66	1,560	1,923	2,391	946	2,009	1,532
67	1,560	1,923	2,391	946	2,009	1,532
68	1,625	2,003	2,492	986	2,093	1,596
69	1,697	2,092	2,587	1,023	2,187	1,668
70	1,766	2,177	2,682	1,060	2,274	1,735
71	1,832	2,258	2,775	1,098	2,360	1,801
72	1,896	2,336	2,863	1,132	2,442	1,862
73	1,957	2,411	2,941	1,164	2,520	1,923
74	2,013	2,479	3,017	1,194	2,591	1,977
75	2,064	2,541	3,086	1,220	2,657	2,027
76	2,112	2,600	3,146	1,244	2,718	2,074
77	2,156	2,655	3,199	1,265	2,775	2,118
78	2,198	2,708	3,247	1,285	2,830	2,158
79	2,235	2,754	3,295	1,304	2,879	2,196
80	2,272	2,800	3,336	1,319	2,925	2,231
81	2,306	2,840	3,378	1,337	2,967	2,264
82	2,335	2,878	3,422	1,354	3,006	2,294
83	2,366	2,915	3,463	1,370	3,046	2,323
84	2,395	2,951	3,504	1,386	3,082	2,351
85	2,423	2,988	3,542	1,401	3,120	2,379
86	2,450	3,020	3,577	1,415	3,154	2,406
87	2,476	3,053	3,616	1,429	3,187	2,431
88	2,503	3,084	3,647	1,442	3,220	2,457
89	2,526	3,114	3,680	1,454	3,251	2,481
90	2,548	3,141	3,710	1,466	3,278	2,501
91	2,570	3,167	3,740	1,477	3,306	2,523
92	2,588	3,190	3,763	1,486	3,330	2,541
93	2,608	3,212	3,788	1,496	3,354	2,560
94	2,625	3,234	3,805	1,504	3,376	2,576
95	2,639	3,253	3,827	1,513	3,395	2,592
96	2,653	3,270	3,847	1,520	3,413	2,606
97	2,671	3,292	3,868	1,527	3,435	2,622
98	2,685	3,310	3,889	1,536	3,454	2,638
99	2,701	3,330	3,906	1,543	3,474	2,653

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0-64	2,904	3,578	4,276	1,691	3,861	2,944
65	1,734	2,135	2,657	1,051	2,232	1,703
66	1,734	2,135	2,657	1,051	2,232	1,703
67	1,734	2,135	2,657	1,051	2,232	1,703
68	1,805	2,224	2,768	1,095	2,325	1,774
69	1,887	2,323	2,874	1,137	2,429	1,854
70	1,962	2,417	2,979	1,178	2,526	1,928
71	2,037	2,508	3,084	1,219	2,622	2,001
72	2,108	2,595	3,181	1,257	2,713	2,070
73	2,176	2,677	3,269	1,293	2,800	2,137
74	2,236	2,753	3,353	1,326	2,879	2,197
75	2,294	2,824	3,428	1,355	2,951	2,253
76	2,346	2,889	3,495	1,382	3,020	2,305
77	2,396	2,950	3,555	1,405	3,084	2,353
78	2,443	3,007	3,609	1,426	3,144	2,400
79	2,485	3,059	3,661	1,447	3,198	2,441
80	2,525	3,109	3,706	1,465	3,251	2,481
81	2,562	3,155	3,754	1,484	3,298	2,517
82	2,596	3,197	3,802	1,503	3,342	2,550
83	2,629	3,238	3,847	1,521	3,386	2,582
84	2,662	3,279	3,893	1,540	3,427	2,614
85	2,695	3,319	3,937	1,557	3,468	2,646
86	2,724	3,355	3,975	1,572	3,506	2,674
87	2,752	3,390	4,017	1,590	3,542	2,703
88	2,781	3,427	4,052	1,603	3,579	2,730
89	2,806	3,458	4,088	1,616	3,612	2,756
90	2,830	3,488	4,124	1,630	3,644	2,780
91	2,855	3,518	4,156	1,642	3,675	2,803
92	2,875	3,543	4,181	1,652	3,702	2,824
93	2,895	3,568	4,210	1,663	3,728	2,844
94	2,915	3,593	4,228	1,671	3,754	2,863
95	2,930	3,612	4,253	1,681	3,774	2,879
96	2,946	3,631	4,274	1,690	3,795	2,895
97	2,966	3,655	4,297	1,698	3,820	2,914
98	2,981	3,675	4,320	1,708	3,841	2,930
99	3,000	3,697	4,338	1,715	3,864	2,947

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.08333

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					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0-64	2,066	2,545	3,042	1,203	2,746	2,095
65	1,233	1,520	1,890	747	1,588	1,211
66	1,233	1,520	1,890	747	1,588	1,211
67	1,233	1,520	1,890	747	1,588	1,211
68	1,284	1,583	1,969	779	1,654	1,262
69	1,341	1,653	2,045	809	1,727	1,318
70	1,395	1,720	2,120	838	1,797	1,371
71	1,448	1,785	2,194	867	1,865	1,422
72	1,498	1,847	2,264	894	1,930	1,472
73	1,546	1,906	2,325	919	1,992	1,519
74	1,590	1,960	2,385	943	2,048	1,563
75	1,630	2,009	2,439	964	2,099	1,602
76	1,669	2,056	2,486	983	2,147	1,639
77	1,704	2,100	2,529	1,000	2,193	1,674
78	1,737	2,141	2,567	1,016	2,237	1,707
79	1,766	2,178	2,604	1,031	2,275	1,736
80	1,795	2,213	2,637	1,043	2,312	1,763
81	1,821	2,246	2,671	1,056	2,346	1,789
82	1,845	2,275	2,705	1,070	2,377	1,813
83	1,869	2,305	2,737	1,082	2,409	1,836
84	1,892	2,333	2,770	1,095	2,438	1,859
85	1,915	2,362	2,800	1,107	2,468	1,882
86	1,936	2,387	2,828	1,118	2,494	1,902
87	1,957	2,412	2,859	1,131	2,520	1,923
88	1,978	2,437	2,883	1,141	2,546	1,944
89	1,996	2,460	2,908	1,151	2,569	1,961
90	2,014	2,481	2,933	1,161	2,591	1,978
91	2,031	2,502	2,957	1,170	2,613	1,994
92	2,047	2,521	2,975	1,177	2,632	2,009
93	2,062	2,539	2,995	1,185	2,651	2,023
94	2,076	2,556	3,008	1,190	2,669	2,036
95	2,087	2,570	3,025	1,197	2,684	2,048
96	2,098	2,584	3,041	1,203	2,699	2,059
97	2,112	2,601	3,057	1,208	2,716	2,072
98	2,123	2,615	3,074	1,215	2,731	2,084
99	2,136	2,630	3,087	1,221	2,747	2,096

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0-64	2,296	2,829	3,380	1,336	3,051	2,328
65	1,370	1,688	2,100	830	1,764	1,346
66	1,370	1,688	2,100	830	1,764	1,346
67	1,370	1,688	2,100	830	1,764	1,346
68	1,427	1,759	2,187	865	1,838	1,403
69	1,490	1,837	2,273	899	1,919	1,466
70	1,551	1,911	2,355	932	1,996	1,524
71	1,609	1,983	2,438	964	2,072	1,582
72	1,664	2,052	2,516	995	2,144	1,637
73	1,718	2,118	2,584	1,022	2,213	1,689
74	1,766	2,177	2,651	1,047	2,275	1,737
75	1,811	2,232	2,710	1,071	2,333	1,781
76	1,853	2,283	2,763	1,092	2,388	1,822
77	1,892	2,331	2,810	1,112	2,438	1,861
78	1,929	2,377	2,853	1,128	2,485	1,897
79	1,962	2,418	2,894	1,144	2,528	1,930
80	1,994	2,457	2,930	1,159	2,569	1,961
81	2,024	2,493	2,968	1,173	2,607	1,990
82	2,050	2,526	3,005	1,188	2,642	2,017
83	2,076	2,559	3,041	1,203	2,676	2,044
84	2,101	2,591	3,078	1,217	2,709	2,068
85	2,126	2,623	3,112	1,231	2,742	2,093
86	2,149	2,651	3,142	1,243	2,771	2,116
87	2,172	2,679	3,176	1,257	2,800	2,138
88	2,195	2,708	3,204	1,268	2,830	2,161
89	2,216	2,733	3,231	1,279	2,856	2,181
90	2,235	2,756	3,259	1,290	2,880	2,199
91	2,254	2,779	3,285	1,301	2,904	2,218
92	2,270	2,800	3,305	1,308	2,925	2,234
93	2,286	2,821	3,328	1,317	2,946	2,251
94	2,302	2,839	3,342	1,323	2,966	2,266
95	2,315	2,855	3,362	1,331	2,983	2,278
96	2,328	2,870	3,378	1,338	3,000	2,291
97	2,343	2,889	3,396	1,344	3,020	2,306
98	2,356	2,904	3,416	1,352	3,037	2,319
99	2,371	2,921	3,430	1,358	3,054	2,332

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

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 Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0-64	2,375	2,928	3,498	1,383	3,158	2,410
65	1,418	1,748	2,174	860	1,826	1,393
66	1,418	1,748	2,174	860	1,826	1,393
67	1,418	1,748	2,174	860	1,826	1,393
68	1,477	1,821	2,265	896	1,903	1,451
69	1,543	1,902	2,352	930	1,988	1,516
70	1,605	1,979	2,438	964	2,067	1,577
71	1,665	2,053	2,523	998	2,145	1,637
72	1,724	2,124	2,603	1,029	2,220	1,693
73	1,779	2,192	2,674	1,058	2,291	1,748
74	1,830	2,254	2,743	1,085	2,355	1,797
75	1,876	2,310	2,805	1,109	2,415	1,843
76	1,920	2,364	2,860	1,131	2,471	1,885
77	1,960	2,414	2,908	1,150	2,523	1,925
78	1,998	2,462	2,952	1,168	2,573	1,962
79	2,032	2,504	2,995	1,185	2,617	1,996
80	2,065	2,545	3,033	1,199	2,659	2,028
81	2,096	2,582	3,071	1,215	2,697	2,058
82	2,123	2,616	3,111	1,231	2,733	2,085
83	2,151	2,650	3,148	1,245	2,769	2,112
84	2,177	2,683	3,185	1,260	2,802	2,137
85	2,203	2,716	3,220	1,274	2,836	2,163
86	2,227	2,745	3,252	1,286	2,867	2,187
87	2,251	2,775	3,287	1,299	2,897	2,210
88	2,275	2,804	3,315	1,311	2,927	2,234
89	2,296	2,831	3,345	1,322	2,955	2,255
90	2,316	2,855	3,373	1,333	2,980	2,274
91	2,336	2,879	3,400	1,343	3,005	2,294
92	2,353	2,900	3,421	1,351	3,027	2,310
93	2,371	2,920	3,444	1,360	3,049	2,327
94	2,386	2,940	3,459	1,367	3,069	2,342
95	2,399	2,957	3,479	1,375	3,086	2,356
96	2,412	2,973	3,497	1,382	3,103	2,369
97	2,428	2,993	3,516	1,388	3,123	2,384
98	2,441	3,009	3,535	1,396	3,140	2,398
99	2,455	3,027	3,551	1,403	3,158	2,412

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0-64	2,640	3,253	3,887	1,537	3,510	2,676
65	1,576	1,941	2,415	955	2,029	1,548
66	1,576	1,941	2,415	955	2,029	1,548
67	1,576	1,941	2,415	955	2,029	1,548
68	1,641	2,022	2,516	995	2,114	1,613
69	1,715	2,112	2,613	1,034	2,208	1,685
70	1,784	2,197	2,708	1,071	2,296	1,753
71	1,852	2,280	2,804	1,108	2,384	1,819
72	1,916	2,359	2,892	1,143	2,466	1,882
73	1,978	2,434	2,972	1,175	2,545	1,943
74	2,033	2,503	3,048	1,205	2,617	1,997
75	2,085	2,567	3,116	1,232	2,683	2,048
76	2,133	2,626	3,177	1,256	2,745	2,095
77	2,178	2,682	3,232	1,277	2,804	2,139
78	2,221	2,734	3,281	1,296	2,858	2,182
79	2,259	2,781	3,328	1,315	2,907	2,219
80	2,295	2,826	3,369	1,332	2,955	2,255
81	2,329	2,868	3,413	1,349	2,998	2,288
82	2,360	2,906	3,456	1,366	3,038	2,318
83	2,390	2,944	3,497	1,383	3,078	2,347
84	2,420	2,981	3,539	1,400	3,115	2,376
85	2,450	3,017	3,579	1,415	3,153	2,405
86	2,476	3,050	3,614	1,429	3,187	2,431
87	2,502	3,082	3,652	1,445	3,220	2,457
88	2,528	3,115	3,684	1,457	3,254	2,482
89	2,551	3,144	3,716	1,469	3,284	2,505
90	2,573	3,171	3,749	1,482	3,313	2,527
91	2,595	3,198	3,778	1,493	3,341	2,548
92	2,614	3,221	3,801	1,502	3,365	2,567
93	2,632	3,244	3,827	1,512	3,389	2,585
94	2,650	3,266	3,844	1,519	3,413	2,603
95	2,664	3,284	3,866	1,528	3,431	2,617
96	2,678	3,301	3,885	1,536	3,450	2,632
97	2,696	3,323	3,906	1,544	3,473	2,649
98	2,710	3,341	3,927	1,553	3,492	2,664
99	2,727	3,361	3,944	1,559	3,513	2,679

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

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 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 all 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
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$0	$1288 (Part A Deductible)
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	$0	Up to $161 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 $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
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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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 $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	$0	Up to $161 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 $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
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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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 $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	Up to $161 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 $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
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 $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$166 (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 $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
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	Up to $161 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 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
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 $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$166 (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 $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•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
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 $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	Up to $161 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 $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
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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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 $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	Up to $161 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 $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
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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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