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

Delaware

Rates Effective: 07/2016 A

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 $4,960; paid at 100% after limit reached	Out-of-pocket limit $2,480; 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 $2,180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2,180. 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: Entire State

Female Rates

Rates Effective 07/01/2016

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65 (ESRD)	21,286	24,505	28,783	25,732	22,730	19,852
Under 65 (non-ESRD)	4,417	5,070	5,951	2,380	4,698	4,100
65	1,306	1,472	1,718	688	1,352	1,176
66	1,343	1,520	1,777	711	1,399	1,217
67	1,379	1,567	1,833	733	1,445	1,258
68	1,414	1,613	1,890	756	1,490	1,299
69	1,450	1,659	1,946	778	1,535	1,339
70	1,486	1,705	2,001	800	1,580	1,379
71	1,520	1,750	2,056	822	1,624	1,418
72	1,554	1,794	2,111	844	1,668	1,457
73	1,583	1,840	2,167	867	1,715	1,499
74	1,613	1,884	2,223	889	1,760	1,541
75	1,641	1,928	2,279	911	1,806	1,583
76	1,670	1,971	2,334	933	1,851	1,624
77	1,698	2,015	2,389	956	1,896	1,665
78	1,717	2,055	2,443	978	1,943	1,708
79	1,735	2,095	2,497	999	1,989	1,751
80	1,752	2,135	2,552	1,021	2,035	1,794
81	1,770	2,175	2,605	1,042	2,080	1,836
82	1,788	2,214	2,658	1,064	2,125	1,878
83	1,811	2,249	2,710	1,084	2,172	1,923
84	1,833	2,285	2,763	1,105	2,218	1,968
85	1,851	2,313	2,808	1,124	2,258	2,007
86	1,869	2,343	2,854	1,141	2,300	2,048
87	1,887	2,372	2,900	1,160	2,342	2,090
88	1,906	2,401	2,947	1,179	2,385	2,132
89	1,924	2,432	2,995	1,198	2,427	2,174
90	1,943	2,460	3,041	1,216	2,470	2,216
91	1,961	2,489	3,086	1,235	2,511	2,257
92	1,980	2,517	3,131	1,253	2,552	2,298
93	1,999	2,545	3,175	1,271	2,593	2,337
94	2,018	2,573	3,219	1,287	2,633	2,377
95	2,038	2,599	3,262	1,305	2,672	2,416
96	2,057	2,625	3,305	1,322	2,711	2,454
97	2,077	2,651	3,347	1,339	2,750	2,492
98	2,097	2,676	3,388	1,356	2,786	2,530
99+	2,118	2,702	3,429	1,371	2,824	2,566

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65 (ESRD)	23,650	27,228	31,981	28,592	25,256	22,058
Under 65 (non-ESRD)	4,908	5,634	6,613	2,645	5,220	4,556
65	1,451	1,636	1,909	764	1,502	1,307
66	1,492	1,689	1,974	790	1,554	1,352
67	1,532	1,741	2,037	815	1,605	1,398
68	1,572	1,792	2,100	840	1,656	1,443
69	1,611	1,844	2,162	864	1,706	1,488
70	1,651	1,894	2,224	889	1,755	1,532
71	1,689	1,945	2,285	914	1,804	1,576
72	1,726	1,994	2,345	938	1,853	1,619
73	1,760	2,044	2,408	964	1,905	1,666
74	1,792	2,093	2,470	988	1,956	1,712
75	1,824	2,142	2,532	1,012	2,007	1,759
76	1,855	2,190	2,594	1,037	2,057	1,804
77	1,887	2,239	2,654	1,062	2,107	1,850
78	1,908	2,283	2,715	1,086	2,159	1,898
79	1,928	2,328	2,774	1,110	2,210	1,946
80	1,947	2,372	2,835	1,134	2,261	1,993
81	1,967	2,416	2,895	1,157	2,311	2,040
82	1,987	2,460	2,953	1,182	2,361	2,087
83	2,013	2,499	3,011	1,204	2,413	2,137
84	2,037	2,539	3,069	1,227	2,464	2,187
85	2,057	2,570	3,120	1,248	2,509	2,230
86	2,077	2,603	3,171	1,268	2,555	2,276
87	2,097	2,636	3,222	1,289	2,602	2,322
88	2,118	2,668	3,275	1,310	2,650	2,369
89	2,138	2,702	3,327	1,331	2,697	2,416
90	2,159	2,733	3,379	1,351	2,744	2,462
91	2,180	2,765	3,429	1,372	2,790	2,508
92	2,201	2,796	3,479	1,392	2,836	2,553
93	2,222	2,828	3,528	1,411	2,881	2,597
94	2,243	2,858	3,577	1,430	2,925	2,641
95	2,265	2,888	3,625	1,450	2,969	2,684
96	2,286	2,917	3,673	1,469	3,012	2,727
97	2,308	2,946	3,719	1,488	3,055	2,769
98	2,330	2,974	3,765	1,506	3,096	2,811
99+	2,353	3,002	3,810	1,524	3,138	2,851

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: Entire State

Male Rates

Rates Effective 07/01/2016

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65 (ESRD)	24,479	28,181	33,100	29,592	26,140	22,830
Under 65 (non-ESRD)	5,080	5,831	6,844	2,737	5,403	4,715
65	1,503	1,693	1,975	791	1,554	1,352
66	1,545	1,748	2,043	818	1,608	1,400
67	1,586	1,802	2,108	843	1,661	1,447
68	1,626	1,854	2,174	869	1,714	1,494
69	1,667	1,908	2,238	895	1,766	1,540
70	1,708	1,961	2,302	920	1,816	1,586
71	1,748	2,013	2,365	945	1,868	1,631
72	1,787	2,063	2,428	971	1,918	1,676
73	1,821	2,116	2,493	998	1,972	1,724
74	1,854	2,166	2,557	1,023	2,024	1,772
75	1,887	2,217	2,621	1,048	2,077	1,820
76	1,920	2,267	2,684	1,073	2,129	1,868
77	1,953	2,317	2,747	1,099	2,181	1,915
78	1,974	2,364	2,810	1,125	2,235	1,964
79	1,995	2,409	2,872	1,149	2,288	2,014
80	2,015	2,455	2,935	1,174	2,340	2,063
81	2,036	2,501	2,996	1,198	2,392	2,111
82	2,056	2,546	3,057	1,223	2,444	2,160
83	2,083	2,586	3,116	1,246	2,498	2,211
84	2,108	2,627	3,177	1,271	2,551	2,263
85	2,128	2,660	3,229	1,293	2,597	2,308
86	2,149	2,694	3,282	1,313	2,644	2,355
87	2,170	2,728	3,335	1,335	2,693	2,404
88	2,191	2,762	3,389	1,356	2,743	2,452
89	2,212	2,796	3,444	1,378	2,792	2,500
90	2,234	2,829	3,497	1,399	2,840	2,548
91	2,255	2,862	3,549	1,420	2,888	2,596
92	2,277	2,895	3,600	1,441	2,935	2,643
93	2,300	2,927	3,652	1,462	2,982	2,688
94	2,321	2,959	3,702	1,481	3,028	2,734
95	2,344	2,988	3,752	1,500	3,073	2,778
96	2,366	3,019	3,801	1,520	3,118	2,822
97	2,389	3,049	3,849	1,539	3,162	2,866
98	2,412	3,078	3,897	1,559	3,204	2,910
99+	2,436	3,107	3,944	1,577	3,248	2,951

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65 (ESRD)	27,198	31,312	36,778	32,881	29,044	25,367
Under 65 (non-ESRD)	5,644	6,480	7,605	3,042	6,003	5,239
65	1,668	1,882	2,196	879	1,727	1,503
66	1,716	1,943	2,270	908	1,787	1,555
67	1,762	2,002	2,343	937	1,845	1,608
68	1,808	2,061	2,415	966	1,904	1,659
69	1,852	2,120	2,486	993	1,962	1,711
70	1,898	2,179	2,558	1,023	2,019	1,762
71	1,943	2,237	2,627	1,051	2,075	1,812
72	1,986	2,293	2,696	1,078	2,131	1,862
73	2,023	2,351	2,769	1,109	2,192	1,916
74	2,061	2,407	2,840	1,136	2,249	1,969
75	2,098	2,463	2,912	1,164	2,309	2,023
76	2,134	2,519	2,983	1,193	2,366	2,075
77	2,170	2,575	3,052	1,221	2,423	2,128
78	2,195	2,625	3,123	1,248	2,483	2,183
79	2,217	2,678	3,190	1,277	2,542	2,238
80	2,239	2,728	3,260	1,304	2,600	2,292
81	2,262	2,778	3,330	1,330	2,658	2,346
82	2,285	2,829	3,396	1,360	2,714	2,400
83	2,315	2,874	3,463	1,385	2,775	2,458
84	2,343	2,920	3,529	1,411	2,834	2,515
85	2,366	2,956	3,588	1,435	2,885	2,565
86	2,389	2,994	3,647	1,458	2,939	2,617
87	2,412	3,031	3,705	1,483	2,993	2,670
88	2,436	3,068	3,766	1,507	3,047	2,724
89	2,458	3,107	3,826	1,531	3,102	2,778
90	2,482	3,143	3,886	1,554	3,155	2,831
91	2,506	3,179	3,944	1,578	3,209	2,884
92	2,531	3,215	4,001	1,601	3,262	2,936
93	2,555	3,252	4,057	1,623	3,313	2,987
94	2,579	3,287	4,114	1,644	3,364	3,037
95	2,605	3,321	4,169	1,667	3,415	3,087
96	2,629	3,355	4,224	1,689	3,464	3,136
97	2,654	3,388	4,277	1,712	3,513	3,184
98	2,680	3,420	4,330	1,731	3,560	3,233
99+	2,706	3,452	4,382	1,752	3,609	3,279

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 a 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
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,288	$0	$1,288 (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 tests, 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 $1,288	$1,288 (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 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 tests, 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 $1,288	$1,288 (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 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 tests, 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

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 $2,180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,180. 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 $2,180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,180 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,288	$1,288 (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 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 $2,180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,180. 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 $2,180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,180 DEDUCTIBLE*** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $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 $2,180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,180 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 $2,180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,180 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 $1,288	$1,288 (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 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 $1,288	$1,288 (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 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