Aetna Health and Life Insurance Company

Administrative Office
800 Crescent Centre Dr.
Suite 200
Franklin, TN 37067
800 264.4000
aetnaseniorproducts.com

Outline of Coverage

Medicare Supplement Insurance

BENEFIT PLANS A, B, F, HIGH DEDUCTIBLE F, G, N

Underwritten by

Aetna Health and Life Insurance Company

North Carolina

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.

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, 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 $[4940]; paid at 100% after limit reached	Out-of-pocket limit $[2470]; 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: Entire State

Male Rates

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	4,202	---	5,624	---	---	---
65	1,242	1,409	1,624	650	1,434	1,125
66	1,278	1,454	1,679	671	1,484	1,164
67	1,313	1,499	1,731	693	1,533	1,203
68	1,346	1,544	1,786	715	1,581	1,242
69	1,380	1,588	1,839	735	1,628	1,280
70	1,413	1,632	1,891	756	1,676	1,318
71	1,447	1,675	1,943	778	1,723	1,356
72	1,479	1,717	1,994	798	1,769	1,393
73	1,507	1,761	2,048	819	1,819	1,434
74	1,535	1,803	2,101	840	1,868	1,473
75	1,561	1,845	2,153	861	1,916	1,513
76	1,589	1,886	2,205	883	1,964	1,553
77	1,616	1,927	2,256	903	2,013	1,592
78	1,633	1,966	2,309	924	2,061	1,633
79	1,651	2,004	2,359	944	2,110	1,674
80	1,667	2,043	2,410	964	2,159	1,715
81	1,684	2,080	2,461	984	2,207	1,755
82	1,701	2,119	2,512	1,005	2,254	1,795
83	1,723	2,153	2,561	1,024	2,303	1,839
84	1,745	2,186	2,610	1,045	2,353	1,881
85	1,762	2,213	2,653	1,062	2,395	1,919
86	1,779	2,241	2,696	1,078	2,440	1,958
87	1,796	2,270	2,739	1,096	2,485	1,998
88	1,813	2,300	2,785	1,113	2,530	2,039
89	1,830	2,327	2,829	1,132	2,575	2,079
90	1,849	2,355	2,873	1,150	2,620	2,118
91	1,866	2,382	2,916	1,167	2,665	2,157
92	1,884	2,409	2,959	1,183	2,707	2,197
93	1,902	2,436	3,001	1,200	2,751	2,236
94	1,922	2,462	3,042	1,217	2,793	2,272
95	1,939	2,487	3,083	1,233	2,835	2,310
96	1,957	2,513	3,123	1,248	2,876	2,347
97	1,977	2,537	3,163	1,265	2,916	2,383
98	1,996	2,562	3,201	1,281	2,957	2,418
99	2,015	2,585	3,239	1,296	2,996	2,454

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	4,669	---	6,248	---	---	---
65	1,380	1,567	1,804	722	1,594	1,250
66	1,420	1,616	1,865	747	1,648	1,293
67	1,458	1,666	1,924	771	1,703	1,336
68	1,496	1,715	1,983	795	1,757	1,380
69	1,534	1,764	2,043	818	1,809	1,423
70	1,570	1,812	2,101	840	1,862	1,464
71	1,608	1,861	2,159	864	1,914	1,507
72	1,643	1,908	2,214	886	1,965	1,548
73	1,675	1,956	2,275	909	2,022	1,594
74	1,705	2,003	2,334	933	2,075	1,636
75	1,736	2,051	2,392	957	2,129	1,681
76	1,765	2,096	2,450	981	2,183	1,725
77	1,796	2,141	2,508	1,004	2,236	1,769
78	1,813	2,184	2,565	1,027	2,290	1,815
79	1,834	2,227	2,622	1,049	2,345	1,861
80	1,852	2,270	2,679	1,071	2,399	1,906
81	1,872	2,311	2,734	1,094	2,452	1,950
82	1,891	2,355	2,791	1,116	2,505	1,994
83	1,915	2,392	2,847	1,137	2,560	2,044
84	1,939	2,429	2,900	1,160	2,614	2,091
85	1,957	2,460	2,947	1,180	2,661	2,132
86	1,977	2,490	2,996	1,198	2,712	2,176
87	1,995	2,522	3,044	1,218	2,761	2,220
88	2,015	2,555	3,093	1,237	2,811	2,266
89	2,034	2,585	3,143	1,257	2,861	2,310
90	2,054	2,617	3,191	1,278	2,911	2,354
91	2,074	2,647	3,239	1,296	2,960	2,397
92	2,093	2,678	3,287	1,315	3,008	2,440
93	2,114	2,706	3,334	1,334	3,057	2,484
94	2,135	2,736	3,380	1,352	3,104	2,525
95	2,155	2,764	3,426	1,369	3,150	2,567
96	2,175	2,792	3,469	1,387	3,196	2,608
97	2,197	2,818	3,514	1,406	3,241	2,647
98	2,219	2,848	3,557	1,424	3,286	2,688
99	2,239	2,873	3,599	1,440	3,328	2,727

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: Entire State
Female Rates

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	3,654	---	4,890	---	---	---
65	1,080	1,225	1,412	565	1,247	978
66	1,111	1,264	1,460	584	1,290	1,012
67	1,141	1,304	1,506	603	1,333	1,046
68	1,171	1,342	1,553	622	1,375	1,080
69	1,200	1,381	1,599	639	1,416	1,113
70	1,229	1,419	1,644	657	1,457	1,146
71	1,258	1,456	1,689	676	1,498	1,179
72	1,286	1,493	1,734	694	1,538	1,211
73	1,310	1,531	1,781	712	1,582	1,247
74	1,335	1,568	1,827	731	1,624	1,281
75	1,358	1,604	1,872	749	1,666	1,316
76	1,382	1,640	1,917	768	1,708	1,350
77	1,405	1,676	1,962	785	1,750	1,384
78	1,420	1,709	2,008	803	1,792	1,420
79	1,435	1,743	2,052	821	1,835	1,456
80	1,450	1,777	2,096	838	1,877	1,491
81	1,465	1,809	2,140	856	1,919	1,526
82	1,479	1,843	2,184	874	1,960	1,561
83	1,498	1,872	2,227	890	2,003	1,599
84	1,517	1,901	2,270	908	2,046	1,636
85	1,532	1,925	2,307	923	2,083	1,669
86	1,547	1,949	2,345	938	2,122	1,703
87	1,561	1,974	2,382	953	2,161	1,737
88	1,577	1,999	2,421	968	2,200	1,773
89	1,592	2,023	2,460	984	2,239	1,808
90	1,608	2,048	2,498	1,000	2,278	1,842
91	1,622	2,072	2,536	1,014	2,317	1,876
92	1,638	2,095	2,573	1,029	2,354	1,910
93	1,654	2,118	2,609	1,044	2,392	1,944
94	1,671	2,141	2,645	1,058	2,429	1,976
95	1,686	2,163	2,681	1,072	2,465	2,009
96	1,702	2,185	2,715	1,086	2,501	2,041
97	1,719	2,206	2,750	1,100	2,536	2,072
98	1,736	2,228	2,784	1,114	2,571	2,103
99	1,752	2,248	2,817	1,127	2,605	2,134

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	4,060	---	5,433	---	---	---
65	1,200	1,362	1,569	628	1,386	1,087
66	1,235	1,405	1,621	649	1,433	1,124
67	1,268	1,449	1,673	670	1,481	1,162
68	1,301	1,491	1,725	691	1,528	1,200
69	1,334	1,534	1,777	711	1,573	1,237
70	1,365	1,576	1,827	731	1,619	1,273
71	1,398	1,618	1,877	752	1,664	1,310
72	1,429	1,659	1,926	771	1,709	1,346
73	1,456	1,701	1,978	791	1,758	1,386
74	1,483	1,742	2,030	812	1,804	1,423
75	1,509	1,783	2,080	832	1,851	1,462
76	1,535	1,823	2,130	853	1,898	1,500
77	1,561	1,862	2,181	873	1,944	1,538
78	1,577	1,899	2,230	893	1,991	1,578
79	1,595	1,936	2,280	912	2,039	1,618
80	1,611	1,974	2,329	931	2,086	1,657
81	1,628	2,010	2,377	951	2,132	1,696
82	1,644	2,048	2,427	970	2,178	1,734
83	1,665	2,080	2,475	989	2,226	1,777
84	1,686	2,112	2,522	1,009	2,273	1,818
85	1,702	2,139	2,563	1,026	2,314	1,854
86	1,719	2,165	2,605	1,042	2,358	1,892
87	1,735	2,193	2,647	1,059	2,401	1,930
88	1,752	2,222	2,690	1,075	2,444	1,970
89	1,768	2,248	2,733	1,093	2,488	2,009
90	1,786	2,275	2,775	1,111	2,531	2,047
91	1,803	2,302	2,817	1,127	2,574	2,084
92	1,820	2,328	2,858	1,143	2,616	2,122
93	1,838	2,353	2,899	1,159	2,658	2,160
94	1,856	2,379	2,939	1,176	2,699	2,196
95	1,873	2,403	2,979	1,191	2,739	2,232
96	1,891	2,428	3,017	1,206	2,779	2,268
97	1,910	2,451	3,056	1,222	2,818	2,302
98	1,929	2,476	3,093	1,238	2,857	2,337
99	1,947	2,498	3,130	1,252	2,894	2,371

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

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 annual 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 2368, Brentwood, Tennessee 37024. 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 [$1260]	$0	[$1260] (Part A Deductible)
61st thru 90th day	All but [$315] a day	[$315] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$630] a day	[$630] 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 [$157.50] a day	$0	Up to [$157.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

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

*Once you have been billed [$147] 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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147]of Medicare Approved amounts*	$0	$0	[$147] (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 [$1260]	[$1260] (Part A Deductible)	$0
61st thru 90th day	All but [$315] a day	[$315] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$630] a day	[$630] 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 [$157.50] a day	$0	Up to [$157.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

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

* Once you have been billed [$147] 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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare Approved amounts*	$0	$0	[$147] (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 [$1260]	[$1260] (Part A Deductible)	$0
61st thru 90th day	All but [$315] a day	[$315] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$630] a day	[$630] 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 [$157.50] a day	Up to [$157.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

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

*Once you have been billed [$147] 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 [$147] of Medicare-Approved amounts*	$0	[$147] (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 [$147] of Medicare-Approved amounts*	$0	[$147] (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 [$147] of Medicare Approved amounts*	$0	[$147] (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 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 [$1260]	[$1260] (Part A Deductible)	$0
61st thru 90th day	All but [$315] a day	[$315] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$630] a day	[$630] 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 [$157.50] a day	Up to [$157.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed [$147] 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 [$147] of Medicare-Approved amounts*	$0	[$147] (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 [$147] of Medicare-Approved amounts*	$0	[$147] (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 [$147] of Medicare Approved amounts*	$0	[$147] (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 [$1260]	[$1260] (Part A Deductible)	$0
61st thru 90th day	All but [$315] a day	[$315] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$630] a day	[$630] 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 [$157.50] a day	Up to [$157.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

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

*Once you have been billed [$147] 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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare Approved amounts*	$0	$0	[$147] (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 [$1260]	[$1260] (Part A Deductible)	$0
61st thru 90th day	All but [$315] a day	[$315] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$630] a day	[$630] 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 [$157.50] a day	Up to [$157.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

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

*Once you have been billed [$147] 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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare Approved amounts*	$0	$0	[$147] (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