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

OKLAHOMA

Rates Effective: 03/2017 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.

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 $5,120; paid at 100% after limit reached	Out-of-pocket limit $2,560; 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 $2,200 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2,200. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the certificate. 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: 730, 731, 740, 741

Female Rates

Rates Effective 3/1/2017

Attained Age	Preferred					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	4,758	---	---	---	---	---
65	1,290	1,433	1,679	660	1,176	1,063
66	1,343	1,498	1,758	691	1,234	1,118
67	1,394	1,564	1,839	723	1,290	1,171
68	1,446	1,631	1,918	754	1,348	1,224
69	1,496	1,695	1,999	785	1,406	1,278
70	1,548	1,763	2,080	818	1,463	1,332
71	1,599	1,827	2,160	849	1,523	1,383
72	1,649	1,893	2,239	880	1,579	1,438
73	1,695	1,962	2,328	914	1,642	1,500
74	1,741	2,031	2,416	949	1,707	1,561
75	1,788	2,102	2,502	983	1,771	1,622
76	1,833	2,171	2,590	1,018	1,834	1,682
77	1,880	2,239	2,678	1,051	1,899	1,745
78	1,900	2,293	2,752	1,081	1,956	1,800
79	1,922	2,346	2,826	1,110	2,010	1,854
80	1,941	2,399	2,898	1,139	2,067	1,911
81	1,962	2,453	2,973	1,168	2,123	1,967
82	1,983	2,506	3,045	1,196	2,177	2,023
83	2,007	2,555	3,120	1,225	2,238	2,084
84	2,032	2,602	3,192	1,255	2,295	2,145
85	2,054	2,643	3,259	1,281	2,348	2,201
86	2,073	2,686	3,326	1,306	2,402	2,260
87	2,094	2,729	3,396	1,334	2,460	2,318
88	2,116	2,772	3,466	1,362	2,516	2,381
89	2,136	2,814	3,535	1,389	2,573	2,441
90	2,156	2,858	3,604	1,416	2,630	2,502
91	2,177	2,899	3,672	1,443	2,686	2,562
92	2,200	2,942	3,742	1,470	2,742	2,623
93	2,222	2,983	3,810	1,496	2,798	2,683
94	2,244	3,022	3,877	1,523	2,852	2,743
95	2,266	3,061	3,943	1,549	2,906	2,801
96	2,287	3,102	4,008	1,574	2,960	2,859
97	2,310	3,141	4,073	1,601	3,013	2,918
98	2,333	3,180	4,138	1,626	3,066	2,974
99+	2,356	3,217	4,202	1,651	3,118	3,030

Attained Age	Standard					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	5,287	---	---	---	---	---
65	1,434	1,593	1,864	734	1,308	1,181
66	1,493	1,666	1,953	768	1,371	1,242
67	1,548	1,738	2,044	804	1,434	1,301
68	1,607	1,814	2,131	837	1,497	1,359
69	1,662	1,884	2,222	873	1,562	1,419
70	1,720	1,958	2,310	906	1,626	1,479
71	1,777	2,030	2,399	943	1,689	1,538
72	1,832	2,103	2,487	979	1,753	1,597
73	1,884	2,182	2,586	1,015	1,825	1,666
74	1,935	2,256	2,684	1,055	1,898	1,733
75	1,987	2,335	2,781	1,093	1,967	1,801
76	2,038	2,413	2,878	1,130	2,039	1,870
77	2,090	2,489	2,976	1,170	2,109	1,937
78	2,111	2,546	3,058	1,202	2,172	1,999
79	2,134	2,607	3,141	1,233	2,234	2,060
80	2,157	2,666	3,220	1,265	2,295	2,124
81	2,182	2,723	3,302	1,298	2,359	2,185
82	2,202	2,784	3,383	1,329	2,418	2,248
83	2,230	2,839	3,466	1,363	2,486	2,314
84	2,259	2,892	3,548	1,394	2,550	2,383
85	2,282	2,938	3,621	1,421	2,611	2,445
86	2,305	2,984	3,697	1,450	2,670	2,512
87	2,328	3,033	3,773	1,481	2,732	2,577
88	2,349	3,080	3,850	1,512	2,796	2,645
89	2,374	3,128	3,927	1,543	2,860	2,714
90	2,395	3,173	4,005	1,573	2,921	2,780
91	2,421	3,221	4,080	1,603	2,984	2,847
92	2,444	3,268	4,157	1,634	3,046	2,914
93	2,469	3,314	4,233	1,662	3,107	2,981
94	2,492	3,358	4,307	1,692	3,169	3,048
95	2,517	3,403	4,382	1,722	3,229	3,112
96	2,542	3,445	4,453	1,749	3,290	3,176
97	2,568	3,489	4,526	1,778	3,349	3,240
98	2,593	3,534	4,597	1,806	3,406	3,305
99+	2,619	3,574	4,669	1,833	3,465	3,367

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: 730, 731, 740, 741

Male Rates

Rates Effective 3/1/2017

Attained	Preferred					
Age	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	5,471	---	---	---	---	---
65	1,485	1,648	1,930	758	1,354	1,222
66	1,543	1,724	2,023	795	1,418	1,286
67	1,603	1,800	2,115	831	1,485	1,346
68	1,662	1,877	2,207	867	1,550	1,408
69	1,720	1,949	2,300	903	1,617	1,469
70	1,780	2,027	2,391	940	1,682	1,531
71	1,839	2,102	2,484	976	1,749	1,590
72	1,896	2,176	2,574	1,012	1,816	1,654
73	1,949	2,255	2,677	1,050	1,887	1,724
74	2,003	2,336	2,777	1,090	1,962	1,794
75	2,056	2,416	2,878	1,130	2,037	1,865
76	2,108	2,496	2,979	1,171	2,110	1,934
77	2,161	2,575	3,080	1,210	2,184	2,006
78	2,186	2,637	3,165	1,243	2,248	2,069
79	2,209	2,699	3,251	1,275	2,312	2,133
80	2,232	2,759	3,333	1,309	2,376	2,198
81	2,255	2,820	3,417	1,343	2,441	2,261
82	2,280	2,881	3,502	1,377	2,505	2,328
83	2,308	2,939	3,587	1,410	2,573	2,395
84	2,337	2,993	3,671	1,443	2,639	2,466
85	2,361	3,039	3,748	1,473	2,701	2,531
86	2,385	3,089	3,826	1,501	2,766	2,599
87	2,409	3,138	3,905	1,533	2,827	2,667
88	2,431	3,187	3,987	1,564	2,893	2,737
89	2,455	3,236	4,065	1,599	2,959	2,808
90	2,479	3,286	4,146	1,627	3,025	2,878
91	2,505	3,333	4,224	1,658	3,089	2,946
92	2,530	3,382	4,302	1,689	3,154	3,015
93	2,555	3,429	4,382	1,720	3,218	3,087
94	2,579	3,475	4,457	1,750	3,280	3,153
95	2,606	3,521	4,534	1,781	3,343	3,222
96	2,630	3,567	4,609	1,811	3,405	3,289
97	2,657	3,613	4,684	1,840	3,465	3,353
98	2,683	3,656	4,759	1,870	3,528	3,420
99+	2,709	3,698	4,831	1,898	3,587	3,486

Attained	Standard					
Age	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	6,079	---	---	---	---	---
65	1,651	1,832	2,144	845	1,502	1,358
66	1,716	1,915	2,246	883	1,577	1,427
67	1,780	1,999	2,351	923	1,649	1,496
68	1,847	2,085	2,452	964	1,723	1,563
69	1,912	2,167	2,555	1,004	1,797	1,632
70	1,978	2,252	2,657	1,044	1,869	1,702
71	2,042	2,335	2,759	1,084	1,944	1,768
72	2,107	2,417	2,861	1,125	2,017	1,837
73	2,167	2,507	2,975	1,167	2,098	1,916
74	2,228	2,597	3,087	1,211	2,182	1,994
75	2,284	2,685	3,198	1,257	2,262	2,070
76	2,344	2,775	3,310	1,301	2,345	2,149
77	2,401	2,861	3,422	1,344	2,427	2,228
78	2,429	2,929	3,517	1,381	2,498	2,299
79	2,454	2,997	3,612	1,417	2,569	2,370
80	2,481	3,066	3,702	1,456	2,639	2,441
81	2,507	3,133	3,797	1,494	2,713	2,513
82	2,533	3,203	3,892	1,528	2,783	2,585
83	2,566	3,265	3,987	1,566	2,858	2,661
84	2,598	3,327	4,080	1,603	2,934	2,740
85	2,624	3,379	4,163	1,635	3,002	2,812
86	2,651	3,433	4,252	1,669	3,073	2,888
87	2,675	3,487	4,339	1,704	3,142	2,964
88	2,703	3,541	4,429	1,739	3,215	3,043
89	2,730	3,596	4,516	1,777	3,288	3,121
90	2,754	3,649	4,606	1,810	3,359	3,196
91	2,783	3,706	4,693	1,843	3,432	3,274
92	2,811	3,759	4,781	1,879	3,503	3,351
93	2,839	3,812	4,866	1,912	3,575	3,428
94	2,866	3,862	4,953	1,946	3,644	3,505
95	2,893	3,912	5,038	1,979	3,713	3,580
96	2,922	3,963	5,121	2,011	3,781	3,654
97	2,953	4,014	5,205	2,044	3,853	3,726
98	2,983	4,064	5,287	2,077	3,918	3,801
99+	3,010	4,110	5,369	2,108	3,985	3,873

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

Female Rates

Rates Effective 3/1/2017

Attained Age	Preferred					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	4,137	---	---	---	---	---
65	1,122	1,246	1,460	574	1,023	924
66	1,168	1,303	1,529	601	1,073	972
67	1,212	1,360	1,599	629	1,122	1,018
68	1,257	1,418	1,668	656	1,172	1,064
69	1,301	1,474	1,738	683	1,223	1,111
70	1,346	1,533	1,809	711	1,272	1,158
71	1,390	1,589	1,878	738	1,324	1,203
72	1,434	1,646	1,947	765	1,373	1,250
73	1,474	1,706	2,024	795	1,428	1,304
74	1,514	1,766	2,101	825	1,484	1,357
75	1,555	1,828	2,176	855	1,540	1,410
76	1,594	1,888	2,252	885	1,595	1,463
77	1,635	1,947	2,329	914	1,651	1,517
78	1,652	1,994	2,393	940	1,701	1,565
79	1,671	2,040	2,457	965	1,748	1,612
80	1,688	2,086	2,520	990	1,797	1,662
81	1,706	2,133	2,585	1,016	1,846	1,710
82	1,724	2,179	2,648	1,040	1,893	1,759
83	1,745	2,222	2,713	1,065	1,946	1,812
84	1,767	2,263	2,776	1,091	1,996	1,865
85	1,786	2,298	2,834	1,114	2,042	1,914
86	1,803	2,336	2,892	1,136	2,089	1,965
87	1,821	2,373	2,953	1,160	2,139	2,016
88	1,840	2,410	3,014	1,184	2,188	2,070
89	1,857	2,447	3,074	1,208	2,237	2,123
90	1,875	2,485	3,134	1,231	2,287	2,176
91	1,893	2,521	3,193	1,255	2,336	2,228
92	1,913	2,558	3,254	1,278	2,384	2,281
93	1,932	2,594	3,313	1,301	2,433	2,333
94	1,951	2,628	3,371	1,324	2,480	2,385
95	1,970	2,662	3,429	1,347	2,527	2,436
96	1,989	2,697	3,485	1,369	2,574	2,486
97	2,009	2,731	3,542	1,392	2,620	2,537
98	2,029	2,765	3,598	1,414	2,666	2,586
99+	2,049	2,797	3,654	1,436	2,711	2,635

Attained Age	Standard					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	4,597	---	---	---	---	---
65	1,247	1,385	1,621	638	1,137	1,027
66	1,298	1,449	1,698	668	1,192	1,080
67	1,346	1,511	1,777	699	1,247	1,131
68	1,397	1,577	1,853	728	1,302	1,182
69	1,445	1,638	1,932	759	1,358	1,234
70	1,496	1,703	2,009	788	1,414	1,286
71	1,545	1,765	2,086	820	1,469	1,337
72	1,593	1,829	2,163	851	1,524	1,389
73	1,638	1,897	2,249	883	1,587	1,449
74	1,683	1,962	2,334	917	1,650	1,507
75	1,728	2,030	2,418	950	1,710	1,566
76	1,772	2,098	2,503	983	1,773	1,626
77	1,817	2,164	2,588	1,017	1,834	1,684
78	1,836	2,214	2,659	1,045	1,889	1,738
79	1,856	2,267	2,731	1,072	1,943	1,791
80	1,876	2,318	2,800	1,100	1,996	1,847
81	1,897	2,368	2,871	1,129	2,051	1,900
82	1,915	2,421	2,942	1,156	2,103	1,955
83	1,939	2,469	3,014	1,185	2,162	2,012
84	1,964	2,515	3,085	1,212	2,217	2,072
85	1,984	2,555	3,149	1,236	2,270	2,126
86	2,004	2,595	3,215	1,261	2,322	2,184
87	2,024	2,637	3,281	1,288	2,376	2,241
88	2,043	2,678	3,348	1,315	2,431	2,300
89	2,064	2,720	3,415	1,342	2,487	2,360
90	2,083	2,759	3,483	1,368	2,540	2,417
91	2,105	2,801	3,548	1,394	2,595	2,476
92	2,125	2,842	3,615	1,421	2,649	2,534
93	2,147	2,882	3,681	1,445	2,702	2,592
94	2,167	2,920	3,745	1,471	2,756	2,650
95	2,189	2,959	3,810	1,497	2,808	2,706
96	2,210	2,996	3,872	1,521	2,861	2,762
97	2,233	3,034	3,936	1,546	2,912	2,817
98	2,255	3,073	3,997	1,570	2,962	2,874
99+	2,277	3,108	4,060	1,594	3,013	2,928

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 3/1/2017

Attained Age	Preferred					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	4,757	---	---	---	---	---
65	1,291	1,433	1,678	659	1,177	1,063
66	1,342	1,499	1,759	691	1,233	1,118
67	1,394	1,565	1,839	723	1,291	1,170
68	1,445	1,632	1,919	754	1,348	1,224
69	1,496	1,695	2,000	785	1,406	1,277
70	1,548	1,763	2,079	817	1,463	1,331
71	1,599	1,828	2,160	849	1,521	1,383
72	1,649	1,892	2,238	880	1,579	1,438
73	1,695	1,961	2,328	913	1,641	1,499
74	1,742	2,031	2,415	948	1,706	1,560
75	1,788	2,101	2,503	983	1,771	1,622
76	1,833	2,170	2,590	1,018	1,835	1,682
77	1,879	2,239	2,678	1,052	1,899	1,744
78	1,901	2,293	2,752	1,081	1,955	1,799
79	1,921	2,347	2,827	1,109	2,010	1,855
80	1,941	2,399	2,898	1,138	2,066	1,911
81	1,961	2,452	2,971	1,168	2,123	1,966
82	1,983	2,505	3,045	1,197	2,178	2,024
83	2,007	2,556	3,119	1,226	2,237	2,083
84	2,032	2,603	3,192	1,255	2,295	2,144
85	2,053	2,643	3,259	1,281	2,349	2,201
86	2,074	2,686	3,327	1,305	2,405	2,260
87	2,095	2,729	3,396	1,333	2,458	2,319
88	2,114	2,771	3,467	1,360	2,516	2,380
89	2,135	2,814	3,535	1,390	2,573	2,442
90	2,156	2,857	3,605	1,415	2,630	2,503
91	2,178	2,898	3,673	1,442	2,686	2,562
92	2,200	2,941	3,741	1,469	2,743	2,622
93	2,222	2,982	3,810	1,496	2,798	2,684
94	2,243	3,022	3,876	1,522	2,852	2,742
95	2,266	3,062	3,943	1,549	2,907	2,802
96	2,287	3,102	4,008	1,575	2,961	2,860
97	2,310	3,142	4,073	1,600	3,013	2,916
98	2,333	3,179	4,138	1,626	3,068	2,974
99+	2,356	3,216	4,201	1,650	3,119	3,031

Attained Age	Standard					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	5,286	---	---	---	---	---
65	1,436	1,593	1,864	735	1,306	1,181
66	1,492	1,665	1,953	768	1,371	1,241
67	1,548	1,738	2,044	803	1,434	1,301
68	1,606	1,813	2,132	838	1,498	1,359
69	1,663	1,884	2,222	873	1,563	1,419
70	1,720	1,958	2,310	908	1,625	1,480
71	1,776	2,030	2,399	943	1,690	1,537
72	1,832	2,102	2,488	978	1,754	1,597
73	1,884	2,180	2,587	1,015	1,824	1,666
74	1,937	2,258	2,684	1,053	1,897	1,734
75	1,986	2,335	2,781	1,093	1,967	1,800
76	2,038	2,413	2,878	1,131	2,039	1,869
77	2,088	2,488	2,976	1,169	2,110	1,937
78	2,112	2,547	3,058	1,201	2,172	1,999
79	2,134	2,606	3,141	1,232	2,234	2,061
80	2,157	2,666	3,219	1,266	2,295	2,123
81	2,180	2,724	3,302	1,299	2,359	2,185
82	2,203	2,785	3,384	1,329	2,420	2,248
83	2,231	2,839	3,467	1,362	2,485	2,314
84	2,259	2,893	3,548	1,394	2,551	2,383
85	2,282	2,938	3,620	1,422	2,610	2,445
86	2,305	2,985	3,697	1,451	2,672	2,511
87	2,326	3,032	3,773	1,482	2,732	2,577
88	2,350	3,079	3,851	1,512	2,796	2,646
89	2,374	3,127	3,927	1,545	2,859	2,714
90	2,395	3,173	4,005	1,574	2,921	2,779
91	2,420	3,223	4,081	1,603	2,984	2,847
92	2,444	3,269	4,157	1,634	3,046	2,914
93	2,469	3,315	4,231	1,663	3,109	2,981
94	2,492	3,358	4,307	1,692	3,169	3,048
95	2,516	3,402	4,381	1,721	3,229	3,113
96	2,541	3,446	4,453	1,749	3,288	3,177
97	2,568	3,490	4,526	1,777	3,350	3,240
98	2,594	3,534	4,597	1,806	3,407	3,305
99+	2,617	3,574	4,669	1,833	3,465	3,368

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 certificates like yours in this state. Premiums for this certificate will increase due to the increase in your age. Upon attainment of an age requiring a rate increase, the renewal premium for the certificate will be the renewal premium then in effect for your attained age. Other certificates may be provided with Issue Age rating and do not increase with age. You should compare Issue Age with Attained Age certificates.

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 be covered by an Aetna Health and Life Insurance Company Medicare supplement certificate. 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 certificate 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 certificates.

READ YOUR CERTIFICATE VERY CAREFULLY

This is only an outline describing your certificate's most important features. The certificate is your insurance contract. You must read the certificate itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN CERTIFICATE

If you find that you are not satisfied with your certificate, you may return it to Aetna Health and Life Insurance Company, P.O. Box 14770, Lexington, KY 40512-4770. If you send the certificate back to us within 30 days after you receive it, we will treat the certificate as if it had never been issued and return all your payments.

CERTIFICATE REPLACEMENT

If you are replacing another health insurance certificate, do **NOT** cancel it until you have actually received your new certificate and are sure you want to keep it.

NOTICE

The certificate 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 enrollment form for the new certificate, be sure to answer truthfully and completely any questions about your medical and health history. The company may cancel your certificate and refuse to pay any claims if you leave out or falsify important medical information.

Review the enrollment form carefully before you sign it. Be certain that all information has been properly recorded.

THE FOLLOWING CHARTS DESCRIBE PLANS A, B, F, HIGH DEDUCTIBLE F, G and N OFFERED BY AETNA HEALTH AND LIFE INSURANCE COMPANY.

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,316	$0	$1,316 (Part A Deductible)
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	$0	Up to $164.50 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 certificate'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 $183 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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare Approved amounts*	$0	$0	$183 (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 $1,316	$1,316 (Part A Deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	$0	Up to $164.50 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 certificate'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 $183 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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare Approved amounts*	$0	$0	$183 (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 $1,316	$1,316 (Part A Deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 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 certificate'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 $183 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 $183 of Medicare-Approved amounts*	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$183 (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 $183 of Medicare Approved amounts*	$0	$183 (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 $2,200 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,200. 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 $2,200 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,200 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,316	$1,316 (Part A Deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 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 $183 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 $2,200 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,200. 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 $2,200 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,200 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 $183 of Medicare-Approved amounts*	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$183 (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 $2,200 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,200 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $183 of Medicare Approved amounts*	$0	$183 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,200 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,200 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 $1,316	$1,316 (Part A Deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 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 certificate'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 $183 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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare Approved amounts*	$0	$0	$183 (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 $1,316	$1,316 (Part A Deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 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 certificate'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 $183 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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 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.
Part B Excess Charges (Above Medicare-Approved amounts)	$0	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare Approved amounts*	$0	$0	$183 (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