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

Kansas

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Rates Effective: 09/2016 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.

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 50%	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	Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $4960; paid at 100% after limit reached	Out-of-pocket limit $2480; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Aetna Health and Life Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: 660-662, 672

Female Rates

Rates Effective 09/01/2016

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,410	1,596	1,861	744	1,411	1,095
65	1,410	1,596	1,861	744	1,411	1,095
66	1,410	1,596	1,861	744	1,411	1,095
67	1,410	1,596	1,861	744	1,411	1,095
68	1,448	1,645	1,920	768	1,456	1,131
69	1,484	1,691	1,977	791	1,499	1,166
70	1,520	1,737	2,033	813	1,543	1,200
71	1,554	1,783	2,089	836	1,586	1,234
72	1,591	1,829	2,145	858	1,629	1,268
73	1,620	1,876	2,201	880	1,675	1,305
74	1,650	1,920	2,257	904	1,720	1,341
75	1,680	1,964	2,316	925	1,766	1,377
76	1,708	2,008	2,371	947	1,810	1,414
77	1,737	2,053	2,426	970	1,854	1,449
78	1,756	2,094	2,482	992	1,899	1,486
79	1,775	2,134	2,538	1,014	1,944	1,524
80	1,794	2,175	2,592	1,037	1,987	1,561
81	1,812	2,217	2,646	1,058	2,032	1,597
82	1,829	2,256	2,699	1,080	2,077	1,634
83	1,852	2,292	2,753	1,102	2,122	1,673
84	1,877	2,328	2,807	1,122	2,167	1,712
85	1,895	2,356	2,852	1,141	2,207	1,747
86	1,912	2,387	2,897	1,159	2,247	1,782
87	1,931	2,418	2,946	1,178	2,289	1,818
88	1,949	2,448	2,994	1,197	2,330	1,855
89	1,969	2,477	3,042	1,216	2,373	1,892
90	1,987	2,507	3,089	1,236	2,412	1,928
91	2,005	2,537	3,135	1,255	2,454	1,964
92	2,025	2,566	3,181	1,272	2,494	1,999
93	2,046	2,593	3,226	1,290	2,533	2,034
94	2,066	2,621	3,269	1,308	2,573	2,068
95	2,085	2,649	3,314	1,327	2,610	2,102
96	2,104	2,675	3,358	1,343	2,650	2,136
97	2,125	2,702	3,400	1,360	2,686	2,169
98	2,146	2,727	3,442	1,377	2,724	2,201
99	2,167	2,753	3,483	1,393	2,759	2,233

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,566	1,772	2,068	826	1,569	1,216
65	1,566	1,772	2,068	826	1,569	1,216
66	1,566	1,772	2,068	826	1,569	1,216
67	1,566	1,772	2,068	826	1,569	1,216
68	1,608	1,827	2,133	854	1,618	1,256
69	1,649	1,879	2,197	879	1,667	1,296
70	1,689	1,931	2,258	904	1,715	1,332
71	1,728	1,981	2,321	928	1,763	1,371
72	1,768	2,032	2,383	954	1,810	1,409
73	1,801	2,083	2,445	978	1,861	1,450
74	1,833	2,133	2,509	1,004	1,912	1,489
75	1,867	2,182	2,572	1,029	1,962	1,530
76	1,899	2,232	2,635	1,054	2,010	1,570
77	1,931	2,281	2,695	1,078	2,059	1,609
78	1,951	2,325	2,758	1,103	2,110	1,652
79	1,972	2,372	2,819	1,128	2,160	1,693
80	1,993	2,418	2,880	1,153	2,208	1,735
81	2,013	2,462	2,940	1,176	2,258	1,774
82	2,032	2,507	2,999	1,200	2,308	1,815
83	2,058	2,547	3,060	1,224	2,357	1,859
84	2,085	2,587	3,117	1,246	2,407	1,902
85	2,104	2,619	3,168	1,267	2,452	1,942
86	2,124	2,652	3,221	1,288	2,496	1,981
87	2,146	2,686	3,274	1,309	2,543	2,021
88	2,166	2,719	3,328	1,331	2,589	2,061
89	2,188	2,753	3,379	1,351	2,636	2,102
90	2,208	2,786	3,432	1,374	2,681	2,143
91	2,229	2,818	3,484	1,394	2,726	2,182
92	2,251	2,851	3,534	1,412	2,771	2,221
93	2,273	2,881	3,584	1,433	2,814	2,261
94	2,296	2,913	3,633	1,453	2,859	2,298
95	2,317	2,943	3,683	1,474	2,901	2,336
96	2,339	2,973	3,731	1,493	2,944	2,374
97	2,362	3,002	3,779	1,510	2,984	2,410
98	2,384	3,031	3,824	1,530	3,026	2,445
99	2,407	3,060	3,870	1,548	3,066	2,482

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: 660-662, 672

Male Rates

Rates Effective 09/01/2016

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,621	1,835	2,141	856	1,624	1,258
65	1,621	1,835	2,141	856	1,624	1,258
66	1,621	1,835	2,141	856	1,624	1,258
67	1,621	1,835	2,141	856	1,624	1,258
68	1,664	1,891	2,207	883	1,675	1,299
69	1,707	1,945	2,273	910	1,725	1,341
70	1,749	1,999	2,339	936	1,774	1,379
71	1,788	2,050	2,402	960	1,825	1,419
72	1,829	2,103	2,466	987	1,874	1,459
73	1,863	2,156	2,531	1,012	1,926	1,499
74	1,898	2,207	2,596	1,040	1,979	1,542
75	1,932	2,257	2,662	1,064	2,031	1,583
76	1,964	2,309	2,726	1,090	2,081	1,626
77	1,999	2,361	2,790	1,115	2,132	1,665
78	2,020	2,407	2,853	1,141	2,184	1,711
79	2,041	2,454	2,918	1,166	2,235	1,752
80	2,063	2,501	2,981	1,192	2,286	1,795
81	2,083	2,549	3,043	1,216	2,338	1,837
82	2,103	2,595	3,105	1,242	2,387	1,878
83	2,131	2,637	3,166	1,266	2,440	1,924
84	2,157	2,677	3,229	1,290	2,492	1,969
85	2,179	2,710	3,280	1,311	2,538	2,009
86	2,199	2,745	3,333	1,333	2,584	2,050
87	2,220	2,779	3,389	1,355	2,632	2,091
88	2,242	2,814	3,443	1,377	2,680	2,133
89	2,265	2,849	3,498	1,399	2,728	2,176
90	2,285	2,884	3,552	1,422	2,775	2,218
91	2,306	2,916	3,606	1,442	2,823	2,258
92	2,330	2,949	3,659	1,462	2,867	2,299
93	2,352	2,982	3,710	1,484	2,913	2,339
94	2,375	3,014	3,761	1,504	2,958	2,378
95	2,398	3,045	3,812	1,526	3,003	2,418
96	2,420	3,078	3,862	1,546	3,047	2,456
97	2,444	3,108	3,911	1,563	3,089	2,494
98	2,467	3,137	3,958	1,583	3,133	2,531
99	2,492	3,166	4,005	1,602	3,174	2,569

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,802	2,037	2,377	949	1,803	1,398
65	1,802	2,037	2,377	949	1,803	1,398
66	1,802	2,037	2,377	949	1,803	1,398
67	1,802	2,037	2,377	949	1,803	1,398
68	1,849	2,101	2,453	981	1,860	1,444
69	1,896	2,159	2,526	1,011	1,917	1,489
70	1,944	2,220	2,597	1,040	1,972	1,533
71	1,987	2,277	2,670	1,067	2,027	1,576
72	2,033	2,338	2,740	1,096	2,082	1,620
73	2,071	2,397	2,813	1,125	2,141	1,667
74	2,107	2,453	2,886	1,155	2,199	1,713
75	2,147	2,510	2,958	1,183	2,256	1,759
76	2,182	2,567	3,029	1,211	2,311	1,806
77	2,220	2,624	3,099	1,240	2,367	1,851
78	2,244	2,674	3,171	1,267	2,427	1,900
79	2,268	2,727	3,242	1,296	2,484	1,947
80	2,291	2,779	3,312	1,326	2,540	1,994
81	2,316	2,831	3,381	1,352	2,597	2,041
82	2,338	2,884	3,450	1,381	2,653	2,087
83	2,368	2,929	3,518	1,408	2,712	2,137
84	2,398	2,974	3,585	1,433	2,769	2,188
85	2,420	3,012	3,644	1,459	2,819	2,232
86	2,443	3,049	3,704	1,481	2,871	2,278
87	2,467	3,089	3,764	1,506	2,925	2,324
88	2,490	3,127	3,827	1,531	2,977	2,371
89	2,517	3,166	3,885	1,553	3,032	2,418
90	2,540	3,204	3,948	1,580	3,083	2,464
91	2,562	3,241	4,006	1,603	3,136	2,509
92	2,588	3,279	4,065	1,625	3,186	2,554
93	2,614	3,313	4,122	1,649	3,236	2,599
94	2,640	3,351	4,179	1,671	3,288	2,642
95	2,663	3,384	4,235	1,695	3,336	2,686
96	2,690	3,419	4,291	1,716	3,385	2,729
97	2,717	3,452	4,345	1,736	3,432	2,771
98	2,741	3,485	4,398	1,760	3,480	2,813
99	2,769	3,518	4,451	1,780	3,526	2,855

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: Rest of state

Female Rates

Rates Effective 09/01/2016

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,282	1,451	1,692	676	1,283	995
65	1,282	1,451	1,692	676	1,283	995
66	1,282	1,451	1,692	676	1,283	995
67	1,282	1,451	1,692	676	1,283	995
68	1,316	1,495	1,745	698	1,324	1,028
69	1,349	1,537	1,797	719	1,363	1,060
70	1,382	1,579	1,848	739	1,403	1,091
71	1,413	1,621	1,899	760	1,442	1,122
72	1,446	1,663	1,950	780	1,481	1,153
73	1,473	1,705	2,001	800	1,523	1,186
74	1,500	1,745	2,052	822	1,564	1,219
75	1,527	1,785	2,105	841	1,605	1,252
76	1,553	1,825	2,155	861	1,645	1,285
77	1,579	1,866	2,205	882	1,685	1,317
78	1,596	1,904	2,256	902	1,726	1,351
79	1,614	1,940	2,307	922	1,767	1,385
80	1,631	1,977	2,356	943	1,806	1,419
81	1,647	2,015	2,405	962	1,847	1,452
82	1,663	2,051	2,454	982	1,888	1,485
83	1,684	2,084	2,503	1,002	1,929	1,521
84	1,706	2,116	2,552	1,020	1,970	1,556
85	1,723	2,142	2,593	1,037	2,006	1,588
86	1,738	2,170	2,634	1,054	2,043	1,620
87	1,755	2,198	2,678	1,071	2,081	1,653
88	1,772	2,225	2,722	1,088	2,118	1,686
89	1,790	2,252	2,765	1,105	2,157	1,720
90	1,806	2,279	2,808	1,124	2,193	1,753
91	1,823	2,306	2,850	1,141	2,231	1,785
92	1,841	2,333	2,892	1,156	2,267	1,817
93	1,860	2,357	2,933	1,173	2,303	1,849
94	1,878	2,383	2,972	1,189	2,339	1,880
95	1,895	2,408	3,013	1,206	2,373	1,911
96	1,913	2,432	3,053	1,221	2,409	1,942
97	1,932	2,456	3,091	1,236	2,442	1,972
98	1,951	2,479	3,129	1,252	2,476	2,001
99	1,970	2,503	3,166	1,266	2,508	2,030

Modal Factors: Semi-Annual: 0.5200

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,424	1,611	1,880	751	1,426	1,105
65	1,424	1,611	1,880	751	1,426	1,105
66	1,424	1,611	1,880	751	1,426	1,105
67	1,424	1,611	1,880	751	1,426	1,105
68	1,462	1,661	1,939	776	1,471	1,142
69	1,499	1,708	1,997	799	1,515	1,178
70	1,535	1,755	2,053	822	1,559	1,211
71	1,571	1,801	2,110	844	1,603	1,246
72	1,607	1,847	2,166	867	1,645	1,281
73	1,637	1,894	2,223	889	1,692	1,318
74	1,666	1,939	2,281	913	1,738	1,354
75	1,697	1,984	2,338	935	1,784	1,391
76	1,726	2,029	2,395	958	1,827	1,427
77	1,755	2,074	2,450	980	1,872	1,463
78	1,774	2,114	2,507	1,003	1,918	1,502
79	1,793	2,156	2,563	1,025	1,964	1,539
80	1,812	2,198	2,618	1,048	2,007	1,577
81	1,830	2,238	2,673	1,069	2,053	1,613
82	1,847	2,279	2,726	1,091	2,098	1,650
83	1,871	2,315	2,782	1,113	2,143	1,690
84	1,895	2,352	2,834	1,133	2,188	1,729
85	1,913	2,381	2,880	1,152	2,229	1,765
86	1,931	2,411	2,928	1,171	2,269	1,801
87	1,951	2,442	2,976	1,190	2,312	1,837
88	1,969	2,472	3,025	1,210	2,354	1,874
89	1,989	2,503	3,072	1,228	2,396	1,911
90	2,007	2,533	3,120	1,249	2,437	1,948
91	2,026	2,562	3,167	1,267	2,478	1,984
92	2,046	2,592	3,213	1,284	2,519	2,019
93	2,066	2,619	3,258	1,303	2,558	2,055
94	2,087	2,648	3,303	1,321	2,599	2,089
95	2,106	2,675	3,348	1,340	2,637	2,124
96	2,126	2,703	3,392	1,357	2,676	2,158
97	2,147	2,729	3,435	1,373	2,713	2,191
98	2,167	2,755	3,476	1,391	2,751	2,223
99	2,188	2,782	3,518	1,407	2,787	2,256

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: Rest of state

Male Rates

Rates Effective 09/01/2016

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,474	1,668	1,946	778	1,476	1,144
65	1,474	1,668	1,946	778	1,476	1,144
66	1,474	1,668	1,946	778	1,476	1,144
67	1,474	1,668	1,946	778	1,476	1,144
68	1,513	1,719	2,006	803	1,523	1,181
69	1,552	1,768	2,066	827	1,568	1,219
70	1,590	1,817	2,126	851	1,613	1,254
71	1,625	1,864	2,184	873	1,659	1,290
72	1,663	1,912	2,242	897	1,704	1,326
73	1,694	1,960	2,301	920	1,751	1,363
74	1,725	2,006	2,360	945	1,799	1,402
75	1,756	2,052	2,420	967	1,846	1,439
76	1,785	2,099	2,478	991	1,892	1,478
77	1,817	2,146	2,536	1,014	1,938	1,514
78	1,836	2,188	2,594	1,037	1,985	1,555
79	1,855	2,231	2,653	1,060	2,032	1,593
80	1,875	2,274	2,710	1,084	2,078	1,632
81	1,894	2,317	2,766	1,105	2,125	1,670
82	1,912	2,359	2,823	1,129	2,170	1,707
83	1,937	2,397	2,878	1,151	2,218	1,749
84	1,961	2,434	2,935	1,173	2,265	1,790
85	1,981	2,464	2,982	1,192	2,307	1,826
86	1,999	2,495	3,030	1,212	2,349	1,864
87	2,018	2,526	3,081	1,232	2,393	1,901
88	2,038	2,558	3,130	1,252	2,436	1,939
89	2,059	2,590	3,180	1,272	2,480	1,978
90	2,077	2,622	3,229	1,293	2,523	2,016
91	2,096	2,651	3,278	1,311	2,566	2,053
92	2,118	2,681	3,326	1,329	2,606	2,090
93	2,138	2,711	3,373	1,349	2,648	2,126
94	2,159	2,740	3,419	1,367	2,689	2,162
95	2,180	2,768	3,465	1,387	2,730	2,198
96	2,200	2,798	3,511	1,405	2,770	2,233
97	2,222	2,825	3,555	1,421	2,808	2,267
98	2,243	2,852	3,598	1,439	2,848	2,301
99	2,265	2,878	3,641	1,456	2,885	2,335

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,638	1,852	2,161	863	1,639	1,271
65	1,638	1,852	2,161	863	1,639	1,271
66	1,638	1,852	2,161	863	1,639	1,271
67	1,638	1,852	2,161	863	1,639	1,271
68	1,681	1,910	2,230	892	1,691	1,313
69	1,724	1,963	2,296	919	1,743	1,354
70	1,767	2,018	2,361	945	1,793	1,394
71	1,806	2,070	2,427	970	1,843	1,433
72	1,848	2,125	2,491	996	1,893	1,473
73	1,883	2,179	2,557	1,023	1,946	1,515
74	1,915	2,230	2,624	1,050	1,999	1,557
75	1,952	2,282	2,689	1,075	2,051	1,599
76	1,984	2,334	2,754	1,101	2,101	1,642
77	2,018	2,385	2,817	1,127	2,152	1,683
78	2,040	2,431	2,883	1,152	2,206	1,727
79	2,062	2,479	2,947	1,178	2,258	1,770
80	2,083	2,526	3,011	1,205	2,309	1,813
81	2,105	2,574	3,074	1,229	2,361	1,855
82	2,125	2,622	3,136	1,255	2,412	1,897
83	2,153	2,663	3,198	1,280	2,465	1,943
84	2,180	2,704	3,259	1,303	2,517	1,989
85	2,200	2,738	3,313	1,326	2,563	2,029
86	2,221	2,772	3,367	1,346	2,610	2,071
87	2,243	2,808	3,422	1,369	2,659	2,113
88	2,264	2,843	3,479	1,392	2,706	2,155
89	2,288	2,878	3,532	1,412	2,756	2,198
90	2,309	2,913	3,589	1,436	2,803	2,240
91	2,329	2,946	3,642	1,457	2,851	2,281
92	2,353	2,981	3,695	1,477	2,896	2,322
93	2,376	3,012	3,747	1,499	2,942	2,363
94	2,400	3,046	3,799	1,519	2,989	2,402
95	2,421	3,076	3,850	1,541	3,033	2,442
96	2,445	3,108	3,901	1,560	3,077	2,481
97	2,470	3,138	3,950	1,578	3,120	2,519
98	2,492	3,168	3,998	1,600	3,164	2,557
99	2,517	3,198	4,046	1,618	3,205	2,595

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 an Aetna Health and Life Insurance Company Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (b) be someone with whom you are in a civil union partnership; or (c) be a permanent resident in your home. The household discount will only be applicable if a policy for each applicant is issued. The discounted rate will be 7 percent lower than the individual rates and will apply as long as both policies remain in force.

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

The policy may not cover all of your medical costs.

Neither Aetna Health and Life Insurance Company nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare & You* for more details.

CANCELLATION BY INSURED

The insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt of such notice or on such late date as may be specified in such notice. In the event of cancellation or death of the insured, the insurer will promptly return the unearned portion of any premium paid beyond the date of termination. The earned premium shall be computed by the use of the pro-rata method. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

GUARANTEED RENEWABLE

You have the right to renew this policy, for consecutive terms, by payment of the required premium before the end of each grace period. You have the right to renew this policy regardless of changes in your physical, mental or health conditions.

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.

YOU HAVE PURCHASED PLAN __________.

PREMIUM FOR THIS PLAN IS $___________.

PREMIUM WILL BE PAID ________________.

AGENT'S NAME:________________________

AGENT'S ADDRESS:____________________

____

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$0	$1288 (Part A Deductible)
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $161.00 a day	$0	Up to $161.00 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN A

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

*Once you have been billed $166 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First $166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	$0 Generally 80%	$0 Generally 20%	$166 (Part B Deductible) $0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD First 3 pints Next $166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	$0 $0 80%	All costs $0 20%	$0 $166 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $161.00 a day	$0	Up to $161.00 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	$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 test, durable medical equipment			
First $166 of Medicare-Approved amounts*	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $166 of Medicare-Approved amounts*	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $161.00 a day	Up to $161.00 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			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	$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 test, durable medical equipment			
First $166 of Medicare-Approved amounts*	$0	$166 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $166 of Medicare-Approved amounts*	$0	$166 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

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

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE PLAN F

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

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

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $161.00 a day	Up to $161.00 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 $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE*** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $166 of Medicare-Approved amounts*	$0	$166 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $166 of Medicare-Approved amounts*	$0	$166 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $161.00 a day	Up to $161.00 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 $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $161.00 a day	Up to $161.00 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.	$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

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