



**Aetna Health and Life  
Insurance Company**

**Administrative Office**

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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**

**Iowa**



**AETNA HEALTH AND LIFE INSURANCE COMPANY**  
**OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 2**  
**BENEFIT PLANS AVAILABLE: A, B, F, HIGH DEDUCTIBLE F, G, N**

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

**Basic Benefits:**

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-Approved expenses) or, co-payments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of coinsurance or copayments

Blood: First three pints of blood each year.

Hospice-Part A coinsurance

<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>F/F*</b>	<b>G</b>	<b>K</b>	<b>L</b>	<b>M</b>	<b>N</b>
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit \$4,960; paid at 100% after limit reached	Out-of-pocket limit \$2,480; paid at 100% after limit reached		

\*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2,180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

**Aetna Health and Life Insurance Company**

Annual Attained Age Premiums

For Use in ZIP Codes: Entire State

Female Rates

Attained Age	Preferred					Standard						
	Plan A	Plan B	Plan F	High F	Plan G	Plan N	Plan A	Plan B	Plan F	High F	Plan G	Plan N
65	1,067	1,116	1,320	528	1,065	877	1,186	1,240	1,467	586	1,184	974
66	1,088	1,144	1,352	541	1,092	899	1,209	1,271	1,502	602	1,213	998
67	1,110	1,173	1,387	554	1,119	921	1,233	1,304	1,541	616	1,243	1,024
68	1,133	1,203	1,422	569	1,148	945	1,259	1,337	1,580	633	1,275	1,050
69	1,156	1,233	1,458	583	1,177	969	1,284	1,371	1,620	648	1,308	1,077
70	1,179	1,265	1,495	598	1,207	994	1,310	1,405	1,661	665	1,341	1,104
71	1,203	1,309	1,548	619	1,250	1,029	1,337	1,455	1,719	688	1,389	1,144
72	1,228	1,355	1,603	642	1,294	1,065	1,364	1,506	1,781	713	1,437	1,184
73	1,253	1,404	1,660	664	1,340	1,103	1,392	1,560	1,845	738	1,489	1,225
74	1,279	1,454	1,719	688	1,388	1,143	1,421	1,616	1,911	765	1,542	1,270
75	1,306	1,506	1,781	712	1,437	1,183	1,450	1,673	1,979	791	1,597	1,314
76	1,333	1,560	1,844	738	1,488	1,226	1,481	1,732	2,049	820	1,653	1,362
77	1,360	1,616	1,909	764	1,542	1,269	1,511	1,795	2,121	849	1,714	1,410
78	1,389	1,674	1,979	792	1,597	1,314	1,543	1,860	2,199	879	1,774	1,460
79	1,418	1,734	2,050	820	1,655	1,362	1,576	1,927	2,278	910	1,838	1,513
80	1,447	1,796	2,123	850	1,714	1,412	1,608	1,996	2,359	944	1,904	1,568
81	1,477	1,860	2,198	879	1,774	1,460	1,642	2,066	2,442	976	1,972	1,622
82	1,507	1,922	2,272	909	1,835	1,510	1,674	2,136	2,525	1,011	2,039	1,677
83	1,540	1,990	2,353	942	1,900	1,564	1,711	2,212	2,615	1,047	2,110	1,738
84	1,572	2,060	2,434	974	1,966	1,618	1,747	2,289	2,704	1,082	2,184	1,797
85	1,602	2,121	2,508	1,003	2,025	1,666	1,780	2,357	2,786	1,115	2,250	1,851
86	1,629	2,184	2,581	1,032	2,084	1,715	1,810	2,427	2,868	1,147	2,316	1,905
87	1,657	2,245	2,655	1,062	2,143	1,764	1,840	2,495	2,949	1,179	2,380	1,959
88	1,684	2,307	2,727	1,091	2,201	1,811	1,871	2,563	3,030	1,212	2,445	2,012
89	1,711	2,366	2,798	1,119	2,258	1,859	1,901	2,629	3,109	1,243	2,509	2,065
90	1,737	2,426	2,867	1,147	2,316	1,905	1,930	2,696	3,186	1,274	2,573	2,117
91	1,763	2,484	2,937	1,175	2,371	1,952	1,958	2,760	3,263	1,306	2,634	2,169
92	1,787	2,541	3,005	1,202	2,426	1,996	1,986	2,823	3,338	1,336	2,696	2,217
93	1,812	2,597	3,070	1,228	2,479	2,040	2,013	2,886	3,412	1,364	2,754	2,267
94	1,836	2,651	3,134	1,254	2,530	2,082	2,040	2,946	3,482	1,393	2,811	2,313
95	1,860	2,703	3,196	1,279	2,580	2,123	2,066	3,003	3,551	1,421	2,866	2,359
96	1,882	2,754	3,256	1,302	2,629	2,163	2,092	3,060	3,618	1,447	2,920	2,404
97	1,904	2,804	3,313	1,325	2,675	2,202	2,116	3,115	3,682	1,472	2,972	2,447
98	1,926	2,850	3,369	1,348	2,719	2,239	2,139	3,167	3,743	1,498	3,022	2,487
99+	1,946	2,894	3,421	1,368	2,763	2,273	2,162	3,216	3,802	1,521	3,069	2,526

Modal Factors: Semi-Annual: 0.5200

Quarterly: 0.2650 Monthly: 0.0833

The above rates do not include the \$20 application fee.

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)

Modal premium x .93 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

# Aetna Health and Life Insurance Company

Annual Attained Age Premiums  
For Use in ZIP Codes: Entire State  
Male Rates

Attained Age	Preferred					Standard						
	Plan A	Plan B	Plan F	High F	Plan G	Plan N	Plan A	Plan B	Plan F	High F	Plan G	Plan N
65	1,227	1,283	1,517	607	1,225	1,009	1,364	1,426	1,687	674	1,361	1,120
66	1,251	1,315	1,555	622	1,256	1,034	1,390	1,462	1,728	692	1,394	1,148
67	1,277	1,349	1,595	637	1,286	1,059	1,418	1,499	1,772	708	1,430	1,177
68	1,302	1,383	1,636	654	1,320	1,086	1,448	1,538	1,817	728	1,467	1,207
69	1,329	1,418	1,677	671	1,354	1,115	1,476	1,576	1,863	745	1,504	1,239
70	1,356	1,455	1,719	688	1,389	1,143	1,507	1,616	1,911	765	1,542	1,269
71	1,383	1,506	1,780	712	1,437	1,184	1,538	1,673	1,977	792	1,597	1,315
72	1,413	1,558	1,844	738	1,488	1,225	1,568	1,731	2,048	820	1,653	1,361
73	1,441	1,615	1,909	764	1,541	1,268	1,601	1,794	2,121	848	1,713	1,408
74	1,471	1,672	1,977	792	1,596	1,314	1,634	1,858	2,197	879	1,773	1,460
75	1,501	1,731	2,048	819	1,653	1,360	1,668	1,923	2,276	909	1,837	1,512
76	1,533	1,794	2,120	848	1,712	1,409	1,703	1,993	2,357	943	1,902	1,566
77	1,564	1,858	2,196	878	1,773	1,459	1,738	2,064	2,440	976	1,971	1,622
78	1,597	1,926	2,276	910	1,837	1,512	1,774	2,138	2,528	1,011	2,040	1,679
79	1,631	1,995	2,358	943	1,903	1,566	1,812	2,216	2,619	1,047	2,114	1,740
80	1,664	2,065	2,442	977	1,971	1,623	1,849	2,295	2,713	1,085	2,189	1,804
81	1,699	2,138	2,527	1,011	2,040	1,679	1,888	2,376	2,808	1,123	2,268	1,865
82	1,732	2,211	2,614	1,045	2,110	1,737	1,926	2,457	2,904	1,162	2,345	1,929
83	1,771	2,289	2,706	1,083	2,185	1,798	1,968	2,543	3,007	1,203	2,427	1,998
84	1,808	2,368	2,799	1,120	2,260	1,861	2,010	2,632	3,110	1,244	2,511	2,067
85	1,841	2,440	2,884	1,153	2,328	1,916	2,047	2,710	3,204	1,282	2,587	2,129
86	1,873	2,511	2,969	1,187	2,398	1,972	2,081	2,791	3,298	1,319	2,663	2,191
87	1,905	2,582	3,053	1,220	2,465	2,028	2,117	2,870	3,392	1,356	2,738	2,253
88	1,936	2,652	3,136	1,255	2,532	2,083	2,151	2,947	3,485	1,393	2,812	2,313
89	1,968	2,722	3,218	1,286	2,597	2,137	2,186	3,023	3,576	1,430	2,885	2,375
90	1,997	2,790	3,297	1,319	2,663	2,191	2,219	3,100	3,664	1,466	2,958	2,434
91	2,027	2,857	3,377	1,351	2,726	2,244	2,252	3,174	3,752	1,501	3,029	2,494
92	2,055	2,922	3,455	1,382	2,790	2,295	2,284	3,246	3,839	1,537	3,100	2,550
93	2,084	2,987	3,531	1,413	2,850	2,346	2,316	3,319	3,924	1,568	3,168	2,607
94	2,111	3,049	3,604	1,442	2,910	2,394	2,346	3,388	4,005	1,603	3,232	2,660
95	2,138	3,108	3,675	1,471	2,967	2,442	2,376	3,454	4,083	1,634	3,296	2,713
96	2,164	3,168	3,744	1,498	3,023	2,487	2,406	3,519	4,161	1,664	3,359	2,765
97	2,189	3,224	3,810	1,524	3,077	2,533	2,433	3,582	4,234	1,692	3,418	2,814
98	2,214	3,278	3,874	1,550	3,128	2,575	2,460	3,642	4,305	1,723	3,475	2,860
99+	2,238	3,329	3,934	1,574	3,177	2,615	2,486	3,699	4,372	1,749	3,529	2,905

Modal Factors: Semi-Annual: 0.5200

Quarterly: 0.2650 Monthly: 0.0833

The above rates do not include the \$20 application fee.

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)

Modal premium x .93 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

## PREMIUM INFORMATION

Aetna Health and Life Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state. Premiums for this policy will increase due to the increase in your age. Upon attainment of an age requiring a rate increase, the renewal premium for the policy will be the renewal premium then in effect for your attained age. Other policies may be provided with Issue Age rating and do not increase with age. You should compare Issue Age with Attained Age policies.

Premiums payable other than 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 1188, 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1,288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$0  \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$1,288 (Part A Deductible) \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0 \$0 \$0	\$0 Up to \$161 a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE –</b> MEDICARE APPROVED SERVICES <ul style="list-style-type: none"> <li>•Medically necessary skilled care services and medical supplies</li> <li>•Durable medical equipment</li> <li>•First \$166 of Medicare Approved amounts*</li> <li>•Remainder of Medicare Approved amounts</li> </ul>	100%  \$0  80%	\$0  \$0  20%	\$0  \$166 (Part B Deductible)  \$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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> <li>•While using 60 lifetime reserve days</li> <li>•Once lifetime reserve days are used:</li> <li>•Additional 365 days</li> <li>•Beyond the Additional 365 days</li> </ul>	<p>All but \$1,288</p> <p>All but \$322 a day</p> <p>All but \$644 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1,288 (Part A Deductible)</p> <p>\$322 a day</p> <p>\$644 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> 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</p> <p>First 20 days</p> <p>21st thru 100th day 101st day and after</p>	<p>All approved amounts</p> <p>All but \$161 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$161 a day</p> <p>All costs</p>
<p><b>BLOOD</b> First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p><b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/ coinsurance</p>	<p>\$0</p>

\*\*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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

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

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> <li>•While using 60 lifetime reserve days</li> <li>•Once lifetime reserve days are used:               <ul style="list-style-type: none"> <li>•Additional 365 days</li> <li>•Beyond the Additional 365 days</li> </ul> </li> </ul>	<p>All but \$1,288</p> <p>All but \$322 a day</p> <p>All but \$644 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1,288 (Part A Deductible)</p> <p>\$322 a day</p> <p>\$644 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> 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</p> <p>First 20 days</p> <p>21st thru 100th day 101st day and after</p>	<p>All approved amounts</p> <p>All but \$161 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$161 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p><b>BLOOD</b> First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p><b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/ coinsurance</p>	<p>\$0</p>

\*\*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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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%	\$166 (Part B Deductible)  Generally 20%	\$0  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0  80%	All costs \$166 (Part B Deductible)  20%	\$0 \$0  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

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

**PLAN F**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

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

## 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 \$2,180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are \$2,180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2,180 DEDUCTIBLE** YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1,288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1,288 (Part A Deductible) \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY                      CARE*</b> 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  21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0  Up to \$161 a day \$0	\$0  \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

<p><b>HOSPICE CARE</b>  You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0
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**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## HIGH DEDUCTIBLE PLAN F

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

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

\*\*This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are \$2,180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2,180 DEDUCTIBLE** YOU PAY
<b>MEDICAL EXPENSES –</b> 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%	\$166 (Part B Deductible)  Generally 20%	\$0  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0  80%	All costs \$166 (Part B Deductible)  20%	\$0 \$0  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0



## HIGH DEDUCTIBLE PLAN F

### PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2,180 DEDUCTIBLE** YOU PAY
<b>HOME HEALTH CARE – MEDICARE APPROVED SERVICES</b> <ul style="list-style-type: none"> <li>•Medically necessary skilled care services and medical supplies</li> <li>•Durable medical equipment</li> <li>•First \$166 of Medicare Approved amounts*</li> <li>•Remainder of Medicare Approved amounts</li> </ul>	100%	\$0	\$0
	\$0	\$166 (Part B Deductible)	\$0
	80%	20%	\$0

### OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2,180 DEDUCTIBLE** YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1,288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1,288 (Part A Deductible) \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0  Up to \$161 a day \$0	\$0  \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

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

**PLAN G**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

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

**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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1,288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1,288 (Part A Deductible) \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0  Up to \$161 a day \$0	\$0  \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<p><b>MEDICAL EXPENSES –</b>            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</p>	<p>\$0             Generally 80%</p>	<p>\$0             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.</p>	<p>\$166            (Part B Deductible)            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.</p>
<p><b>Part B Excess Charges</b>            (Above Medicare-Approved amounts)</p>	<p>\$0</p>	<p>\$0</p>	<p>All costs</p>
<p><b>BLOOD</b>            First 3 pints            Next \$166 of Medicare-Approved amounts*            Remainder of Medicare-Approved amounts</p>	<p>\$0            \$0             80%</p>	<p>All costs            \$0             20%</p>	<p>\$0            \$166            (Part B Deductible)             \$0</p>
<p><b>CLINICAL LABORATORY SERVICES –</b>            TESTS FOR DIAGNOSTIC SERVICES</p>	<p>100%</p>	<p>\$0</p>	<p>\$0</p>

**PLAN N**

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE – MEDICARE APPROVED SERVICES</b> <ul style="list-style-type: none"> <li>•Medically necessary skilled care services and medical supplies</li> <li>•Durable medical equipment</li> <li>•First \$166 of Medicare Approved amounts*</li> <li>•Remainder of Medicare Approved amounts</li> </ul>	 100%  \$0  80%	 \$0  \$0  20%	 \$0  \$166 (Part B Deductible)  \$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

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

