



**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**

**Ohio**



**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, copayments 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	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 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	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		

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

# Aetna Health and Life Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: 434-36, 440-45, 450-54

Female Rates

Attained Age	Preferred					Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan N	
65	1,156	1,425	1,776	701	1,279	1,285	1,582	1,972	779	1,422	1,342
66	1,156	1,425	1,776	701	1,279	1,285	1,582	1,972	779	1,422	1,342
67	1,156	1,425	1,776	701	1,279	1,285	1,582	1,972	779	1,422	1,342
68	1,204	1,484	1,849	730	1,332	1,339	1,649	2,055	812	1,481	1,399
69	1,259	1,550	1,922	759	1,391	1,399	1,722	2,135	842	1,547	1,462
70	1,309	1,613	1,990	786	1,448	1,454	1,791	2,211	873	1,610	1,519
71	1,360	1,673	2,059	815	1,503	1,510	1,860	2,288	903	1,670	1,577
72	1,407	1,731	2,123	840	1,555	1,562	1,924	2,359	931	1,727	1,632
73	1,452	1,787	2,182	864	1,605	1,613	1,986	2,424	958	1,783	1,684
74	1,493	1,838	2,239	886	1,650	1,658	2,042	2,486	982	1,832	1,731
75	1,531	1,884	2,288	906	1,692	1,700	2,094	2,542	1,004	1,878	1,775
76	1,567	1,927	2,333	924	1,730	1,739	2,142	2,592	1,024	1,923	1,815
77	1,600	1,969	2,373	940	1,767	1,776	2,188	2,637	1,042	1,964	1,854
78	1,632	2,007	2,409	953	1,802	1,810	2,230	2,675	1,057	2,001	1,890
79	1,660	2,041	2,443	967	1,833	1,842	2,268	2,714	1,073	2,037	1,923
80	1,687	2,075	2,473	980	1,863	1,872	2,305	2,748	1,087	2,070	1,954
81	1,712	2,104	2,505	991	1,890	1,899	2,338	2,784	1,100	2,099	1,983
82	1,735	2,133	2,538	1,004	1,915	1,924	2,370	2,819	1,115	2,127	2,010
83	1,758	2,161	2,567	1,016	1,940	1,949	2,401	2,853	1,129	2,155	2,035
84	1,779	2,187	2,598	1,028	1,965	1,973	2,430	2,886	1,142	2,182	2,060
85	1,801	2,212	2,627	1,040	1,988	1,996	2,459	2,918	1,154	2,208	2,085
86	1,820	2,237	2,652	1,050	2,010	2,018	2,485	2,947	1,166	2,232	2,107
87	1,840	2,261	2,682	1,061	2,032	2,040	2,512	2,980	1,177	2,256	2,130
88	1,860	2,284	2,705	1,070	2,053	2,061	2,537	3,005	1,188	2,281	2,154
89	1,876	2,306	2,728	1,078	2,072	2,081	2,561	3,030	1,198	2,302	2,172
90	1,893	2,326	2,751	1,088	2,090	2,099	2,583	3,058	1,208	2,322	2,191
91	1,909	2,345	2,772	1,096	2,107	2,118	2,604	3,081	1,218	2,340	2,209
92	1,923	2,363	2,790	1,103	2,121	2,133	2,624	3,101	1,225	2,357	2,226
93	1,937	2,379	2,809	1,111	2,137	2,148	2,643	3,121	1,233	2,375	2,242
94	1,950	2,395	2,822	1,116	2,151	2,162	2,661	3,136	1,239	2,391	2,258
95	1,960	2,409	2,838	1,124	2,163	2,174	2,675	3,153	1,245	2,405	2,270
96	1,972	2,421	2,853	1,129	2,175	2,186	2,691	3,170	1,253	2,417	2,283
97	1,985	2,438	2,868	1,134	2,188	2,200	2,708	3,186	1,259	2,433	2,298
98	1,995	2,451	2,882	1,141	2,201	2,211	2,724	3,204	1,265	2,447	2,311
99	2,008	2,464	2,896	1,147	2,213	2,225	2,739	3,217	1,272	2,461	2,326

Modal Factors: 0.5200

Semi-Annual:

0.2650

Monthly:

0.0833

The rates do not include the \$20 policy 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: 434-36, 440-45, 450-54

Male Rates

Attained Age	Preferred						Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,329	1,638	2,041	807	1,470	1,390	1,477	1,819	2,268	896	1,634	1,544
66	1,329	1,638	2,041	807	1,470	1,390	1,477	1,819	2,268	896	1,634	1,544
67	1,329	1,638	2,041	807	1,470	1,390	1,477	1,819	2,268	896	1,634	1,544
68	1,384	1,706	2,126	840	1,532	1,448	1,539	1,895	2,363	932	1,703	1,609
69	1,446	1,782	2,209	873	1,600	1,513	1,608	1,979	2,455	969	1,779	1,680
70	1,505	1,853	2,288	904	1,664	1,574	1,672	2,058	2,543	1,004	1,850	1,746
71	1,561	1,924	2,369	935	1,727	1,633	1,735	2,136	2,631	1,038	1,918	1,812
72	1,616	1,991	2,442	965	1,787	1,691	1,796	2,210	2,713	1,071	1,986	1,875
73	1,667	2,055	2,508	991	1,845	1,744	1,852	2,282	2,788	1,099	2,051	1,936
74	1,715	2,113	2,575	1,017	1,896	1,793	1,905	2,346	2,859	1,129	2,108	1,990
75	1,758	2,165	2,631	1,041	1,945	1,839	1,952	2,406	2,924	1,154	2,162	2,040
76	1,799	2,214	2,683	1,061	1,990	1,881	1,997	2,461	2,981	1,176	2,210	2,087
77	1,836	2,263	2,729	1,079	2,033	1,920	2,040	2,514	3,031	1,197	2,259	2,132
78	1,872	2,307	2,770	1,096	2,073	1,958	2,080	2,562	3,078	1,214	2,302	2,172
79	1,905	2,347	2,809	1,112	2,108	1,992	2,116	2,606	3,122	1,232	2,340	2,209
80	1,936	2,385	2,843	1,126	2,143	2,024	2,150	2,648	3,159	1,247	2,379	2,245
81	1,964	2,419	2,881	1,139	2,174	2,054	2,182	2,688	3,201	1,263	2,414	2,277
82	1,990	2,452	2,918	1,154	2,202	2,081	2,210	2,724	3,242	1,279	2,447	2,308
83	2,016	2,484	2,953	1,168	2,230	2,107	2,240	2,759	3,280	1,295	2,478	2,338
84	2,041	2,515	2,987	1,181	2,259	2,134	2,267	2,792	3,319	1,310	2,508	2,367
85	2,065	2,545	3,021	1,194	2,286	2,160	2,294	2,826	3,356	1,324	2,539	2,394
86	2,088	2,571	3,049	1,206	2,311	2,183	2,318	2,856	3,389	1,338	2,566	2,420
87	2,112	2,599	3,083	1,220	2,335	2,205	2,344	2,886	3,427	1,352	2,594	2,447
88	2,134	2,626	3,111	1,230	2,360	2,228	2,369	2,917	3,456	1,364	2,621	2,473
89	2,154	2,651	3,137	1,240	2,382	2,248	2,390	2,944	3,485	1,374	2,646	2,495
90	2,171	2,673	3,165	1,250	2,403	2,268	2,411	2,968	3,516	1,386	2,669	2,517
91	2,190	2,696	3,189	1,260	2,424	2,287	2,431	2,994	3,543	1,397	2,691	2,538
92	2,206	2,715	3,209	1,267	2,442	2,305	2,449	3,016	3,566	1,406	2,711	2,557
93	2,223	2,735	3,231	1,277	2,460	2,322	2,465	3,037	3,590	1,414	2,731	2,575
94	2,238	2,753	3,246	1,282	2,475	2,337	2,482	3,058	3,607	1,422	2,749	2,592
95	2,249	2,769	3,264	1,288	2,489	2,350	2,496	3,074	3,626	1,429	2,764	2,606
96	2,262	2,784	3,280	1,296	2,502	2,364	2,511	3,092	3,646	1,436	2,779	2,621
97	2,276	2,802	3,297	1,302	2,518	2,378	2,526	3,112	3,662	1,445	2,797	2,638
98	2,288	2,817	3,316	1,309	2,531	2,391	2,540	3,130	3,684	1,452	2,812	2,652
99	2,303	2,834	3,331	1,315	2,546	2,406	2,556	3,148	3,701	1,460	2,830	2,668

Modal Factors: Quarterly: 0.2650 Monthly: 0.0833

Modal Factors: Semi-Annual: 0.5200

The rates do not include the \$20 policy 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

Attained Age	Preferred						Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,101	1,357	1,691	668	1,218	1,151	1,224	1,507	1,878	742	1,354	1,278
66	1,101	1,357	1,691	668	1,218	1,151	1,224	1,507	1,878	742	1,354	1,278
67	1,101	1,357	1,691	668	1,218	1,151	1,224	1,507	1,878	742	1,354	1,278
68	1,147	1,413	1,761	695	1,269	1,199	1,275	1,570	1,957	773	1,410	1,332
69	1,199	1,476	1,830	723	1,325	1,252	1,332	1,640	2,033	802	1,473	1,392
70	1,247	1,536	1,895	749	1,379	1,303	1,385	1,706	2,106	831	1,533	1,447
71	1,295	1,593	1,961	776	1,431	1,352	1,438	1,771	2,179	860	1,590	1,502
72	1,340	1,649	2,022	800	1,481	1,400	1,488	1,832	2,247	887	1,645	1,554
73	1,383	1,702	2,078	823	1,529	1,445	1,536	1,891	2,309	912	1,698	1,604
74	1,422	1,750	2,132	844	1,571	1,485	1,579	1,945	2,368	935	1,745	1,649
75	1,458	1,794	2,179	863	1,611	1,522	1,619	1,994	2,421	956	1,789	1,690
76	1,492	1,835	2,222	880	1,648	1,557	1,656	2,040	2,469	975	1,831	1,729
77	1,524	1,875	2,260	895	1,683	1,590	1,691	2,084	2,511	992	1,870	1,766
78	1,554	1,911	2,294	908	1,716	1,621	1,724	2,124	2,548	1,007	1,906	1,800
79	1,581	1,944	2,327	921	1,746	1,649	1,754	2,160	2,585	1,022	1,940	1,831
80	1,607	1,976	2,355	933	1,774	1,676	1,783	2,195	2,617	1,035	1,971	1,861
81	1,630	2,004	2,386	944	1,800	1,701	1,809	2,227	2,651	1,048	1,999	1,889
82	1,652	2,031	2,417	956	1,824	1,723	1,832	2,257	2,685	1,062	2,026	1,914
83	1,674	2,058	2,445	968	1,848	1,746	1,856	2,287	2,717	1,075	2,052	1,938
84	1,694	2,083	2,474	979	1,871	1,767	1,879	2,314	2,749	1,088	2,078	1,962
85	1,715	2,107	2,502	990	1,893	1,789	1,901	2,342	2,779	1,099	2,103	1,986
86	1,733	2,130	2,526	1,000	1,914	1,809	1,922	2,367	2,807	1,110	2,126	2,007
87	1,752	2,153	2,554	1,010	1,935	1,828	1,943	2,392	2,838	1,121	2,149	2,029
88	1,771	2,175	2,576	1,019	1,955	1,848	1,963	2,416	2,862	1,131	2,172	2,051
89	1,787	2,196	2,598	1,027	1,973	1,865	1,982	2,439	2,886	1,141	2,192	2,069
90	1,803	2,215	2,620	1,036	1,990	1,882	1,999	2,460	2,912	1,150	2,211	2,087
91	1,818	2,233	2,640	1,044	2,007	1,898	2,017	2,480	2,934	1,160	2,229	2,104
92	1,831	2,250	2,657	1,050	2,020	1,913	2,031	2,499	2,953	1,167	2,245	2,120
93	1,845	2,266	2,675	1,058	2,035	1,927	2,046	2,517	2,972	1,174	2,262	2,135
94	1,857	2,281	2,688	1,063	2,049	1,939	2,059	2,534	2,987	1,180	2,277	2,150
95	1,867	2,294	2,703	1,070	2,060	1,950	2,070	2,548	3,003	1,186	2,290	2,162
96	1,878	2,306	2,717	1,075	2,071	1,960	2,082	2,563	3,019	1,193	2,302	2,174
97	1,890	2,322	2,731	1,080	2,084	1,972	2,095	2,579	3,034	1,199	2,317	2,189
98	1,900	2,334	2,745	1,087	2,096	1,983	2,106	2,594	3,051	1,205	2,330	2,201
99	1,912	2,347	2,758	1,092	2,108	1,994	2,119	2,609	3,064	1,211	2,344	2,215

Quarterly: 0.2650      Monthly: 0.0833

Modal Factors:      Semi-Annual: 0.5200

The rates do not include the \$20 policy 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

Attained Age	Preferred					Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,266	1,560	1,944	769	1,400	1,407	1,732	2,160	853	1,556	1,470
66	1,266	1,560	1,944	769	1,400	1,407	1,732	2,160	853	1,556	1,470
67	1,266	1,560	1,944	769	1,400	1,407	1,732	2,160	853	1,556	1,470
68	1,318	1,625	2,025	800	1,459	1,466	1,805	2,250	888	1,622	1,532
69	1,377	1,697	2,104	831	1,524	1,531	1,885	2,338	923	1,694	1,600
70	1,433	1,765	2,179	861	1,585	1,592	1,960	2,422	956	1,762	1,663
71	1,487	1,832	2,256	890	1,645	1,652	2,034	2,506	989	1,827	1,726
72	1,539	1,896	2,326	919	1,702	1,710	2,105	2,584	1,020	1,891	1,786
73	1,588	1,957	2,389	944	1,757	1,764	2,173	2,655	1,047	1,953	1,844
74	1,633	2,012	2,452	969	1,806	1,814	2,234	2,723	1,075	2,008	1,895
75	1,674	2,062	2,506	991	1,852	1,859	2,291	2,785	1,099	2,059	1,943
76	1,713	2,109	2,555	1,010	1,895	1,902	2,344	2,839	1,120	2,105	1,988
77	1,749	2,155	2,599	1,028	1,936	1,943	2,394	2,887	1,140	2,151	2,030
78	1,783	2,197	2,638	1,044	1,974	1,981	2,440	2,931	1,156	2,192	2,069
79	1,814	2,235	2,675	1,059	2,008	2,015	2,482	2,973	1,173	2,229	2,104
80	1,844	2,271	2,708	1,072	2,041	2,048	2,522	3,009	1,188	2,266	2,138
81	1,870	2,304	2,744	1,085	2,070	2,078	2,560	3,049	1,203	2,299	2,169
82	1,895	2,335	2,779	1,099	2,097	2,105	2,594	3,088	1,218	2,330	2,198
83	1,920	2,366	2,812	1,112	2,124	2,133	2,628	3,124	1,233	2,360	2,227
84	1,944	2,395	2,845	1,125	2,151	2,159	2,659	3,161	1,248	2,389	2,254
85	1,967	2,424	2,877	1,137	2,177	2,185	2,691	3,196	1,261	2,418	2,280
86	1,989	2,449	2,904	1,149	2,201	2,208	2,720	3,228	1,274	2,444	2,305
87	2,011	2,475	2,936	1,162	2,224	2,232	2,749	3,264	1,288	2,470	2,330
88	2,032	2,501	2,963	1,171	2,248	2,256	2,778	3,291	1,299	2,496	2,355
89	2,051	2,525	2,988	1,181	2,269	2,276	2,804	3,319	1,309	2,520	2,376
90	2,068	2,546	3,014	1,190	2,289	2,296	2,827	3,349	1,320	2,542	2,397
91	2,086	2,568	3,037	1,200	2,309	2,315	2,851	3,374	1,330	2,563	2,417
92	2,101	2,586	3,056	1,207	2,326	2,332	2,872	3,396	1,339	2,582	2,435
93	2,117	2,605	3,077	1,216	2,343	2,348	2,892	3,419	1,347	2,601	2,452
94	2,131	2,622	3,091	1,221	2,357	2,364	2,912	3,435	1,354	2,618	2,469
95	2,142	2,637	3,109	1,227	2,370	2,377	2,928	3,453	1,361	2,632	2,482
96	2,154	2,651	3,124	1,234	2,383	2,391	2,945	3,472	1,368	2,647	2,496
97	2,168	2,669	3,140	1,240	2,398	2,406	2,964	3,488	1,376	2,664	2,512
98	2,179	2,683	3,158	1,247	2,410	2,419	2,981	3,509	1,383	2,678	2,526
99	2,193	2,699	3,172	1,252	2,425	2,434	2,998	3,525	1,390	2,695	2,541

Quarterly: 0.2650      Monthly: 0.0833

Modal Factors:      Semi-Annual: 0.5200

The rates do not include the \$20 policy fee.

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

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

## PREMIUM INFORMATION

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

Premiums payable other than annually will be determined according to the following factors:

Semi-annual: 0.5200 Quarterly: 0.2650 Monthly  
EFT: 0.0833.

## HOUSEHOLD DISCOUNT

In order to be eligible for the Household discount under an Aetna Health and Life Insurance Company Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently be covered by a Aetna Health and Life Insurance Company Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (b) be someone with whom you are in a civil union partnership; or (c) be a permanent resident in your home. The household discount will only be applicable if a policy for each applicant is issued. The discounted rate will be 7 percent lower than the individual rates. Both policies must remain in force to maintain the discount. The household discount will be discontinued in the event of: (1) divorce or death of the spouse; (2) your civil union partnership is terminated, or; (3) you or the other insured person no longer permanently reside at the same address.

## 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<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 \$1288</p> <p>All but \$322 a day</p> <p>All but \$644 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>\$322 a day</p> <p>\$644 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$1288 (Part A Deductible)</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 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 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 •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 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>
<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 \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1288 (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 \$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 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	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 C**

**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 \$1288</p> <p>All but \$322 a day</p> <p>All but \$644 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1288 (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 C**

**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	\$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 \$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	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 C**

**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 D**

**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 \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1288 (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.	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 D**

**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	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 D**

**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 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
<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 \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1288 (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.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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

**PLAN F**

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

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

<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	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**

<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 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
<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 \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1288 (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.	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 \$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
<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 \$2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2180 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> </ul>	100%	\$0	\$0
<ul style="list-style-type: none"> <li>•Durable medical equipment</li> <li>•First \$166 of Medicare Approved amounts*</li> </ul>	\$0	\$166 (Part B Deductible)	\$0
<ul style="list-style-type: none"> <li>•Remainder of Medicare Approved amounts</li> </ul>	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
<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.

SERVICES	MEDICARE PAYS	PLAN PAYS	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 \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1288 (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>
<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 K

\*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$4960 each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess charges”) and you will be responsible for paying the difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

### 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
<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 \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$644 (Part A Deductible) \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$644 (50% of 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  Up to \$80.50 a day  \$0	\$0  Up to \$80.50 a day ◆ All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	50%◆ \$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	50% of copayment/coinsurance	50% of Medicare copayment/coinsurance♦
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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.

**PLAN K**

**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****	\$0	\$0	\$166 (Part B deductible)****◆
Preventive Benefits for Medicare Covered Services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare-Approved amounts	Generally 80%	Generally 10%	Generally 10%◆
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$4960*
<b>BLOOD</b> First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 Generally 80%	50% \$0 (Part B Deductible) Generally 10%	50%◆ \$166 (Part B deductible)****◆ Generally 10%◆
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

\*this plan limits your out-of-pocket payments for Medicare-approved amounts to \$4960 per year. However, this limit does NOT include charges from your provider that exceed Medicare approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**PLAN K**

**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>			
•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%	10%	10%

\*\*\*\* Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.



## PLAN L

\*You will pay one-fourth the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$2480 each calendar year. The amounts that count toward your annual limit are noted with diamonds (◆) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess charges”) and you will be responsible for paying the difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

### 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
<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 \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$966 (Part A Deductible) \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$322 (25% of 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  Up to \$120.75 a day \$0	\$0  Up to \$40.25 a day ◆ All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	75% \$0	25%◆ \$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	75% of copayment/coinsurance	25% of Medicare copayment/coinsurance♦
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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.

**PLAN L**

**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****	\$0	\$0	\$166 (Part B deductible)****◆
Preventive Benefits for Medicare Covered Services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare-Approved amounts	Generally 80%	Generally 15%	Generally 5%◆
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$2480*
<b>BLOOD</b> First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 Generally 80%	75% \$0 (Part B Deductible) Generally 15%	25%◆ \$166 (Part B deductible)****◆ Generally 5%◆
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

\*this plan limits your out-of-pocket payments for Medicare-approved amounts to \$2480 per year. However, this limit does NOT include charges from your provider that exceed Medicare approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**PLAN L**

**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>			
•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%	15%	5%

\*\*\*\* Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

**PLAN M**

**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 \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$644 (50% of Part A Deductible) \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$644 (50% of 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  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 M**

**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

**PLAN M**

**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>			
•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**

<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	\$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.

<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 \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1288 (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 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 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>\$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>			
•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**

<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	\$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



