Aetna Health and Life Insurance Company

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

Outline of Coverage

Medicare Supplement Insurance

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

Underwritten by

Aetna Health and Life Insurance Company

COLORADO

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

A	B	C	D	F/F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $[4940]; paid at 100% after limit reached	Out-of-pocket limit $[2470]; paid at 100% after limit reached		

*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 [$2140] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed [$2140]. 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: 800-802

Male Rates

Attained Age	Non-Smoker					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0-64	2,010	2,477	2,960	1,170	2,699	2,099
65	1,425	1,756	2,125	840	1,913	1,487
66	1,425	1,756	2,125	840	1,913	1,487
67	1,425	1,756	2,125	840	1,913	1,487
68	1,484	1,829	2,214	876	1,993	1,550
69	1,550	1,911	2,300	910	2,082	1,619
70	1,613	1,988	2,384	943	2,166	1,684
71	1,673	2,063	2,467	976	2,247	1,748
72	1,731	2,134	2,545	1,007	2,325	1,808
73	1,788	2,202	2,615	1,034	2,400	1,867
74	1,838	2,264	2,682	1,060	2,467	1,920
75	1,884	2,321	2,742	1,085	2,530	1,968
76	1,928	2,375	2,796	1,106	2,588	2,013
77	1,969	2,426	2,844	1,124	2,643	2,056
78	2,008	2,473	2,886	1,142	2,695	2,096
79	2,042	2,516	2,928	1,158	2,741	2,132
80	2,075	2,556	2,966	1,173	2,785	2,166
81	2,105	2,594	3,003	1,188	2,826	2,198
82	2,133	2,628	3,042	1,203	2,863	2,226
83	2,160	2,662	3,078	1,218	2,901	2,255
84	2,187	2,695	3,114	1,232	2,936	2,283
85	2,213	2,728	3,148	1,245	2,971	2,310
86	2,237	2,758	3,180	1,257	3,003	2,335
87	2,262	2,787	3,214	1,271	3,035	2,361
88	2,286	2,817	3,242	1,282	3,067	2,386
89	2,307	2,844	3,270	1,293	3,095	2,408
90	2,327	2,868	3,298	1,304	3,122	2,429
91	2,346	2,892	3,324	1,313	3,148	2,450
92	2,364	2,913	3,345	1,321	3,171	2,467
93	2,382	2,934	3,367	1,330	3,194	2,485
94	2,397	2,954	3,383	1,337	3,215	2,501
95	2,410	2,970	3,401	1,344	3,233	2,516
96	2,423	2,987	3,419	1,351	3,251	2,530
97	2,439	3,006	3,438	1,357	3,271	2,547
98	2,452	3,023	3,456	1,365	3,289	2,561
99	2,466	3,040	3,472	1,372	3,309	2,576

Attained Age	Smoker					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0-64	2,234	2,752	3,289	1,300	3,000	2,331
65	1,583	1,950	2,362	934	2,125	1,653
66	1,583	1,950	2,362	934	2,125	1,653
67	1,583	1,950	2,362	934	2,125	1,653
68	1,649	2,032	2,460	972	2,214	1,723
69	1,723	2,122	2,555	1,011	2,313	1,800
70	1,792	2,207	2,648	1,047	2,406	1,872
71	1,860	2,290	2,741	1,084	2,497	1,943
72	1,925	2,369	2,828	1,118	2,584	2,010
73	1,987	2,445	2,906	1,148	2,666	2,075
74	2,043	2,515	2,980	1,178	2,741	2,133
75	2,094	2,578	3,047	1,205	2,811	2,187
76	2,143	2,638	3,106	1,228	2,875	2,237
77	2,188	2,694	3,160	1,249	2,937	2,285
78	2,231	2,747	3,208	1,267	2,994	2,330
79	2,269	2,794	3,254	1,286	3,046	2,369
80	2,306	2,839	3,295	1,302	3,095	2,408
81	2,340	2,881	3,337	1,319	3,141	2,443
82	2,371	2,919	3,379	1,335	3,182	2,475
83	2,401	2,958	3,419	1,352	3,224	2,507
84	2,431	2,994	3,461	1,368	3,264	2,538
85	2,461	3,031	3,499	1,384	3,303	2,569
86	2,487	3,064	3,533	1,397	3,339	2,596
87	2,514	3,097	3,571	1,412	3,374	2,624
88	2,540	3,130	3,603	1,425	3,409	2,651
89	2,563	3,158	3,633	1,437	3,441	2,675
90	2,585	3,186	3,665	1,449	3,471	2,698
91	2,607	3,213	3,694	1,460	3,500	2,721
92	2,626	3,236	3,717	1,469	3,526	2,741
93	2,644	3,259	3,742	1,478	3,551	2,761
94	2,662	3,281	3,759	1,485	3,575	2,780
95	2,676	3,299	3,780	1,494	3,595	2,795
96	2,691	3,317	3,798	1,502	3,615	2,811
97	2,708	3,339	3,819	1,509	3,639	2,829
98	2,723	3,356	3,840	1,518	3,659	2,845
99	2,739	3,376	3,857	1,525	3,681	2,861

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.08333

The rates do not include the $20 policy fee.

To calculate household discount:

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

Modal premium x .95=discounted premium

Aetna Health and Life Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: 800-802

Female Rates

Attained Age	Non-Smoker						Attained Age	Smoker					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N		Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0-64	1,748	2,154	2,574	1,018	2,347	1,825	0-64	1,943	2,394	2,860	1,131	2,608	2,027
65	1,239	1,527	1,848	730	1,663	1,294	65	1,376	1,696	2,054	812	1,848	1,438
66	1,239	1,527	1,848	730	1,663	1,294	66	1,376	1,696	2,054	812	1,848	1,438
67	1,239	1,527	1,848	730	1,663	1,294	67	1,376	1,696	2,054	812	1,848	1,438
68	1,290	1,591	1,925	761	1,733	1,348	68	1,433	1,767	2,138	846	1,925	1,498
69	1,348	1,661	2,000	791	1,810	1,408	69	1,497	1,846	2,222	879	2,011	1,565
70	1,401	1,728	2,072	820	1,882	1,464	70	1,558	1,920	2,302	911	2,091	1,628
71	1,454	1,793	2,145	848	1,954	1,519	71	1,616	1,992	2,384	943	2,170	1,690
72	1,505	1,856	2,213	875	2,022	1,572	72	1,672	2,061	2,460	972	2,246	1,748
73	1,553	1,915	2,274	899	2,087	1,623	73	1,726	2,127	2,527	999	2,319	1,804
74	1,597	1,969	2,332	922	2,145	1,669	74	1,774	2,187	2,592	1,024	2,384	1,855
75	1,638	2,019	2,385	943	2,199	1,711	75	1,819	2,242	2,650	1,047	2,444	1,902
76	1,676	2,066	2,431	961	2,250	1,750	76	1,861	2,294	2,702	1,068	2,501	1,946
77	1,712	2,110	2,473	978	2,298	1,788	77	1,901	2,342	2,748	1,087	2,554	1,988
78	1,745	2,151	2,510	993	2,343	1,823	78	1,938	2,388	2,790	1,103	2,604	2,026
79	1,774	2,188	2,547	1,008	2,384	1,854	79	1,971	2,429	2,829	1,119	2,649	2,061
80	1,803	2,223	2,578	1,020	2,422	1,883	80	2,003	2,468	2,864	1,133	2,692	2,094
81	1,829	2,256	2,611	1,033	2,457	1,911	81	2,033	2,505	2,902	1,147	2,731	2,125
82	1,854	2,286	2,644	1,046	2,490	1,936	82	2,059	2,538	2,938	1,162	2,768	2,154
83	1,878	2,316	2,676	1,058	2,523	1,961	83	2,086	2,571	2,973	1,176	2,804	2,182
84	1,901	2,344	2,708	1,070	2,554	1,986	84	2,111	2,603	3,010	1,190	2,838	2,209
85	1,924	2,373	2,738	1,082	2,585	2,010	85	2,136	2,635	3,043	1,203	2,872	2,235
86	1,945	2,398	2,765	1,093	2,613	2,032	86	2,159	2,663	3,072	1,216	2,903	2,259
87	1,966	2,423	2,795	1,106	2,640	2,054	87	2,182	2,692	3,105	1,229	2,934	2,284
88	1,987	2,449	2,819	1,115	2,668	2,076	88	2,206	2,720	3,133	1,240	2,965	2,308
89	2,005	2,472	2,844	1,125	2,692	2,094	89	2,226	2,746	3,159	1,251	2,992	2,329
90	2,023	2,493	2,868	1,135	2,715	2,112	90	2,245	2,769	3,187	1,262	3,017	2,349
91	2,041	2,514	2,891	1,144	2,738	2,130	91	2,264	2,792	3,212	1,272	3,043	2,368
92	2,056	2,532	2,908	1,151	2,758	2,145	92	2,280	2,813	3,232	1,279	3,065	2,386
93	2,071	2,551	2,928	1,158	2,778	2,160	93	2,297	2,834	3,254	1,288	3,087	2,404
94	2,086	2,567	2,941	1,164	2,796	2,175	94	2,312	2,852	3,268	1,294	3,108	2,420
95	2,097	2,582	2,958	1,170	2,812	2,187	95	2,325	2,868	3,287	1,301	3,125	2,433
96	2,108	2,596	2,973	1,176	2,827	2,199	96	2,339	2,883	3,303	1,308	3,143	2,446
97	2,122	2,613	2,989	1,181	2,846	2,213	97	2,354	2,902	3,321	1,315	3,164	2,463
98	2,133	2,627	3,005	1,188	2,861	2,225	98	2,367	2,917	3,340	1,322	3,181	2,476
99	2,146	2,642	3,018	1,194	2,878	2,239	99	2,382	2,935	3,354	1,328	3,200	2,490

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.08333

The rates do not include the $20 policy fee.

To calculate household discount:

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

Modal premium x .95=discounted premium

Aetna Health and Life Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of state

Male Rates

Attained Age	Non-Smoker					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0-64	1,827	2,252	2,691	1,064	2,454	1,908
65	1,295	1,596	1,932	764	1,739	1,352
66	1,295	1,596	1,932	764	1,739	1,352
67	1,295	1,596	1,932	764	1,739	1,352
68	1,349	1,663	2,013	796	1,812	1,409
69	1,409	1,737	2,091	827	1,893	1,472
70	1,466	1,807	2,167	857	1,969	1,531
71	1,521	1,875	2,243	887	2,043	1,589
72	1,574	1,940	2,314	915	2,114	1,644
73	1,625	2,002	2,377	940	2,182	1,697
74	1,671	2,058	2,438	964	2,243	1,745
75	1,713	2,110	2,493	986	2,300	1,789
76	1,753	2,159	2,542	1,005	2,353	1,830
77	1,790	2,205	2,585	1,022	2,403	1,869
78	1,825	2,248	2,624	1,038	2,450	1,905
79	1,856	2,287	2,662	1,053	2,492	1,938
80	1,886	2,324	2,696	1,066	2,532	1,969
81	1,914	2,358	2,730	1,080	2,569	1,998
82	1,939	2,389	2,765	1,094	2,603	2,024
83	1,964	2,420	2,798	1,107	2,637	2,050
84	1,988	2,450	2,831	1,120	2,669	2,075
85	2,012	2,480	2,862	1,132	2,701	2,100
86	2,034	2,507	2,891	1,143	2,730	2,123
87	2,056	2,534	2,922	1,155	2,759	2,146
88	2,078	2,561	2,947	1,165	2,788	2,169
89	2,097	2,585	2,973	1,175	2,814	2,189
90	2,115	2,607	2,998	1,185	2,838	2,208
91	2,133	2,629	3,022	1,194	2,862	2,227
92	2,149	2,648	3,041	1,201	2,883	2,243
93	2,165	2,667	3,061	1,209	2,904	2,259
94	2,179	2,685	3,075	1,215	2,923	2,274
95	2,191	2,700	3,092	1,222	2,939	2,287
96	2,203	2,715	3,108	1,228	2,955	2,300
97	2,217	2,733	3,125	1,234	2,974	2,315
98	2,229	2,748	3,142	1,241	2,990	2,328
99	2,242	2,764	3,156	1,247	3,008	2,342

Attained Age	Smoker					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0-64	2,031	2,502	2,990	1,182	2,727	2,119
65	1,439	1,773	2,147	849	1,932	1,503
66	1,439	1,773	2,147	849	1,932	1,503
67	1,439	1,773	2,147	849	1,932	1,503
68	1,499	1,847	2,236	884	2,013	1,566
69	1,566	1,929	2,323	919	2,103	1,636
70	1,629	2,006	2,407	952	2,187	1,702
71	1,691	2,082	2,492	985	2,270	1,766
72	1,750	2,154	2,571	1,016	2,349	1,827
73	1,806	2,223	2,642	1,044	2,424	1,886
74	1,857	2,286	2,709	1,071	2,492	1,939
75	1,904	2,344	2,770	1,095	2,555	1,988
76	1,948	2,398	2,824	1,116	2,614	2,034
77	1,989	2,449	2,873	1,135	2,670	2,077
78	2,028	2,497	2,916	1,152	2,722	2,118
79	2,063	2,540	2,958	1,169	2,769	2,154
80	2,096	2,581	2,995	1,184	2,814	2,189
81	2,127	2,619	3,034	1,199	2,855	2,221
82	2,155	2,654	3,072	1,214	2,893	2,250
83	2,183	2,689	3,108	1,229	2,931	2,279
84	2,210	2,722	3,146	1,244	2,967	2,307
85	2,237	2,755	3,181	1,258	3,003	2,335
86	2,261	2,785	3,212	1,270	3,035	2,360
87	2,285	2,815	3,246	1,284	3,067	2,385
88	2,309	2,845	3,275	1,295	3,099	2,410
89	2,330	2,871	3,303	1,306	3,128	2,432
90	2,350	2,896	3,332	1,317	3,155	2,453
91	2,370	2,921	3,358	1,327	3,182	2,474
92	2,387	2,942	3,379	1,335	3,205	2,492
93	2,404	2,963	3,402	1,344	3,228	2,510
94	2,420	2,983	3,417	1,350	3,250	2,527
95	2,433	2,999	3,436	1,358	3,268	2,541
96	2,446	3,015	3,453	1,365	3,286	2,555
97	2,462	3,035	3,472	1,372	3,308	2,572
98	2,475	3,051	3,491	1,380	3,326	2,586
99	2,490	3,069	3,506	1,386	3,346	2,601

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

The rates do not include the $20 policy fee.

To calculate household discount:

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

Modal premium x .95=discounted premium

Aetna Health and Life Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of state

Female Rates

Attained Age	Non-Smoker					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0-64	1,589	1,958	2,340	925	2,134	1,659
65	1,126	1,388	1,680	664	1,512	1,176
66	1,126	1,388	1,680	664	1,512	1,176
67	1,126	1,388	1,680	664	1,512	1,176
68	1,173	1,446	1,750	692	1,575	1,225
69	1,225	1,510	1,818	719	1,645	1,280
70	1,274	1,571	1,884	745	1,711	1,331
71	1,322	1,630	1,950	771	1,776	1,381
72	1,368	1,687	2,012	795	1,838	1,429
73	1,412	1,741	2,067	817	1,897	1,475
74	1,452	1,790	2,120	838	1,950	1,517
75	1,489	1,835	2,168	857	1,999	1,555
76	1,524	1,878	2,210	874	2,045	1,591
77	1,556	1,918	2,248	889	2,089	1,625
78	1,586	1,955	2,282	903	2,130	1,657
79	1,613	1,989	2,315	916	2,167	1,685
80	1,639	2,021	2,344	927	2,202	1,712
81	1,663	2,051	2,374	939	2,234	1,737
82	1,685	2,078	2,404	951	2,264	1,760
83	1,707	2,105	2,433	962	2,294	1,783
84	1,728	2,131	2,462	973	2,322	1,805
85	1,749	2,157	2,489	984	2,350	1,827
86	1,768	2,180	2,514	994	2,375	1,847
87	1,787	2,203	2,541	1,005	2,400	1,867
88	1,806	2,226	2,563	1,014	2,425	1,887
89	1,823	2,247	2,585	1,023	2,447	1,904
90	1,839	2,266	2,607	1,032	2,468	1,920
91	1,855	2,285	2,628	1,040	2,489	1,936
92	1,869	2,302	2,644	1,046	2,507	1,950
93	1,883	2,319	2,662	1,053	2,525	1,964
94	1,896	2,334	2,674	1,058	2,542	1,977
95	1,906	2,347	2,689	1,064	2,556	1,988
96	1,916	2,360	2,703	1,069	2,570	1,999
97	1,929	2,375	2,717	1,074	2,587	2,012
98	1,939	2,388	2,732	1,080	2,601	2,023
99	1,951	2,402	2,744	1,085	2,616	2,035

Attained Age	Smoker					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0-64	1,766	2,176	2,600	1,028	2,371	1,843
65	1,251	1,542	1,867	738	1,680	1,307
66	1,251	1,542	1,867	738	1,680	1,307
67	1,251	1,542	1,867	738	1,680	1,307
68	1,303	1,606	1,944	769	1,750	1,362
69	1,361	1,678	2,020	799	1,828	1,423
70	1,416	1,745	2,093	828	1,901	1,480
71	1,469	1,811	2,167	857	1,973	1,536
72	1,520	1,874	2,236	884	2,042	1,589
73	1,569	1,934	2,297	908	2,108	1,640
74	1,613	1,988	2,356	931	2,167	1,686
75	1,654	2,038	2,409	952	2,222	1,729
76	1,692	2,085	2,456	971	2,274	1,769
77	1,728	2,129	2,498	988	2,322	1,807
78	1,762	2,171	2,536	1,003	2,367	1,842
79	1,792	2,208	2,572	1,017	2,408	1,874
80	1,821	2,244	2,604	1,030	2,447	1,904
81	1,848	2,277	2,638	1,043	2,483	1,932
82	1,872	2,307	2,671	1,056	2,516	1,958
83	1,896	2,337	2,703	1,069	2,549	1,984
84	1,919	2,366	2,736	1,082	2,580	2,008
85	1,942	2,395	2,766	1,094	2,611	2,032
86	1,963	2,421	2,793	1,105	2,639	2,054
87	1,984	2,447	2,823	1,117	2,667	2,076
88	2,005	2,473	2,848	1,127	2,695	2,098
89	2,024	2,496	2,872	1,137	2,720	2,117
90	2,041	2,517	2,897	1,147	2,743	2,135
91	2,058	2,538	2,920	1,156	2,766	2,153
92	2,073	2,557	2,938	1,163	2,786	2,169
93	2,088	2,576	2,958	1,171	2,806	2,185
94	2,102	2,593	2,971	1,176	2,825	2,200
95	2,114	2,607	2,988	1,183	2,841	2,212
96	2,126	2,621	3,003	1,189	2,857	2,224
97	2,140	2,638	3,019	1,195	2,876	2,239
98	2,152	2,652	3,036	1,202	2,892	2,251
99	2,165	2,668	3,049	1,207	2,909	2,264

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

The rates do not include the $20 policy fee.

To calculate household discount:

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

Modal premium x .95=discounted premium

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 5 percent lower than the individual rates and will apply as long as both policies remain in force.

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Aetna Health and Life Insurance Company, P.O. Box 2368, Brentwood, Tennessee 37024. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

POLICY REPLACEMENT

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

NOTICE

The policy may not cover all of your medical costs.

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1216]	$0	[$1216] (Part A Deductible)
61st thru 90th day	All but [$304] a day	[$304] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$608] a day	[$608] a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$152.00] a day	$0	Up to [$152.00] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN A

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

*Once you have been billed [$147] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First [$147] of Medicare-Approved amounts*	$0	$0	[$147] (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$147] of Medicare-Approved amounts*	$0	$0	[$147] (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First [$147] of Medicare Approved amounts*	$0	$0	[$147] (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1216]	[$1216] (Part A Deductible)	$0
61st thru 90th day	All but [$304] a day	[$304] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$608] a day	[$608] a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$152.00] a day	$0	Up to [$152.00] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN B

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

* Once you have been billed [$147] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First [$147] of Medicare-Approved amounts*	$0	$0	[$147] (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$147] of Medicare-Approved amounts*	$0	$0	[$147] (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First [$147] of Medicare Approved amounts*	$0	$0	[$147] (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1216]	[$1216] (Part A Deductible)	$0
61st thru 90th day	All but [$304] a day	[$304] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$608] a day	[$608] a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$152.00] a day	Up to [$152.00] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 F

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

*Once you have been billed [$147] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First [$147] of Medicare-Approved amounts*	$0	[$147] (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$147] of Medicare-Approved amounts*	$0	[$147] (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First [$147] of Medicare Approved amounts*	$0	[$147] (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

High Deductible F

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

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

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2140] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are [$2140]. 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 [$2140] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [$2140] DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1216]	[$1216] (Part A Deductible)	$0
61st thru 90th day	All but [$304] a day	[$304] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$608] a day	[$608] a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$152.00] a day	Up to [$152.00] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

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

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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.

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed [$147] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2140] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are [$2140]. 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 [$2140] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [$2140] DEDUCTIBLE*** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First [$147] of Medicare-Approved amounts*	$0	[$147] (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$147] of Medicare-Approved amounts*	$0	[$147] (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2140] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [$2140] DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment •First [$147] of Medicare Approved amounts*	$0	[$147] (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2140] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2140] DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1216]	[$1216] (Part A Deductible)	$0
61st thru 90th day	All but [$304] a day	[$304] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$608] a day	[$608] a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$152.00] a day	Up to [$152.00] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 G

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

*Once you have been billed [$147] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First [$147] of Medicare-Approved amounts*	$0	$0	[$147] (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$147] of Medicare-Approved amounts*	$0	$0	[$147] (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First [$147] of Medicare Approved amounts*	$0	$0	[$147] (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1216]	[$1216] (Part A Deductible)	$0
61st thru 90th day	All but [$304] a day	[$304] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$608] a day	[$608] a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$152.00] a day	Up to [$152.00] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 N

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

*Once you have been billed [$147] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First [$147] of Medicare-Approved amounts*	$0	$0	[$147] (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to [$20] per office visit and up to [$50] per emergency room visit. The copayment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-Approved amounts)	$0	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$147] of Medicare-Approved amounts*	$0	$0	[$147] (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment •First [$147] of Medicare Approved amounts*	$0	$0	[$147] (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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