

**Aetna Life Insurance Company
Outline of Medicare Supplement Coverage**

Benefit Plans A, B, F, G and N are Offered

This chart shows the benefits included in each of the standard Medicare supplement plans. Every insurer must make available Plan "A." Some plans may not be available in your state.

See Outlines of Coverage Section for details about ALL plans.

Basic Benefits:

- **Hospitalization** - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** - Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insured to pay a portion of Part B coinsurance or copayments.
- **Blood** - First three pints of blood each year.
- **Hospice** - Part A coinsurance.

A	B	C	D	F I 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 \$4,940; paid at 100% after limit reached***	Out-of-pocket limit \$2,470; paid at 100% after limit reached***		

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

**Plans K and L provide for different cost-sharing for items and services than the other plans.

Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges." You will be responsible for payment of excess charges.

***The out-of-pocket annual limit will increase each year for inflation.

PREMIUM INFORMATION

Questions? We're here to help.

Just call us at 1-800-345-6022
(TTY: 711)

We, Aetna Life Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this state, when your age changes or to coincide with changes in Medicare. Changes to plan premiums will take effect on your plan anniversary date. Aetna will send a written notice at least 45 days before the change becomes effective.

The monthly premiums shown will apply when payment is made on a quarterly, semi-annual or annual basis or if you elect to have your payments automatically deducted from your checking account (Electronic Funds Transfer program) or credit card account. To obtain quarterly premium, multiply the monthly premium by 3. For semi-annual premium and annual premium, multiply the monthly premium by 6 or 12, respectively. If you elect to pay your premium on a monthly basis by check or money order, add \$2 to the monthly premium shown to calculate your monthly premium amount.

If you smoke and you enroll other than during the Medicare Supplement Open Enrollment and Guaranteed issue rights periods, a smoker premium rate will apply. Please refer to the Guaranteed Issue Guidelines notice included in your enrollment materials for details on open enrollment and guaranteed issue rights. Smoker premium rates are determined by multiplying the premium shown by a factor of 1.10.

MONTHLY PREMIUMS

Attained Age	PLAN A		PLAN B		PLAN F		PLAN G		PLAN N	
	MALE	FEMALE								
65	\$154.41	\$142.58	\$171.91	\$157.83	\$195.08	\$179.33	\$175.58	\$163.41	\$136.99	\$127.74
66	\$160.24	\$147.99	\$178.33	\$163.74	\$202.33	\$186.08	\$184.08	\$171.24	\$143.74	\$133.99
67	\$165.99	\$153.33	\$184.83	\$169.66	\$209.66	\$192.83	\$192.41	\$178.99	\$150.49	\$140.24
68	\$172.74	\$159.49	\$193.33	\$177.49	\$219.57	\$201.91	\$200.83	\$186.83	\$157.16	\$146.49
69	\$179.41	\$165.66	\$201.83	\$185.33	\$229.49	\$210.99	\$209.24	\$194.66	\$163.83	\$152.74
70	\$186.08	\$171.83	\$210.32	\$193.08	\$239.32	\$219.99	\$217.57	\$202.41	\$170.58	\$158.99
71	\$192.74	\$177.91	\$218.82	\$200.83	\$249.07	\$229.07	\$225.91	\$210.16	\$177.24	\$165.16
72	\$199.33	\$183.99	\$227.16	\$208.57	\$258.82	\$237.99	\$234.24	\$217.91	\$183.91	\$171.41
73	\$203.83	\$188.24	\$234.32	\$215.07	\$267.32	\$245.82	\$243.49	\$226.49	\$191.41	\$178.41
74	\$208.33	\$192.33	\$241.32	\$221.49	\$275.66	\$253.49	\$252.66	\$235.07	\$198.91	\$185.41
75	\$212.82	\$196.49	\$248.32	\$227.99	\$284.07	\$261.24	\$261.82	\$243.57	\$206.33	\$192.33
76	\$217.32	\$200.66	\$255.41	\$234.41	\$292.49	\$268.91	\$270.99	\$252.07	\$213.82	\$199.24
77	\$221.74	\$204.74	\$262.41	\$240.82	\$300.82	\$276.57	\$280.07	\$260.57	\$221.24	\$206.24
78	\$225.07	\$207.74	\$267.24	\$245.24	\$306.82	\$282.16	\$287.82	\$267.74	\$227.82	\$212.32
79	\$228.24	\$210.66	\$271.91	\$249.57	\$312.82	\$287.66	\$295.49	\$274.91	\$234.32	\$218.41
80	\$231.24	\$213.49	\$276.49	\$253.82	\$318.65	\$292.99	\$303.07	\$281.91	\$240.74	\$224.41
81	\$234.16	\$216.24	\$281.16	\$258.07	\$324.57	\$298.40	\$310.74	\$289.07	\$247.16	\$230.41
82	\$236.99	\$218.82	\$285.82	\$262.32	\$330.40	\$303.82	\$318.32	\$296.07	\$253.66	\$236.41
83	\$238.91	\$220.57	\$291.32	\$267.41	\$338.24	\$310.99	\$333.40	\$310.15	\$266.99	\$248.82
84	\$240.66	\$222.16	\$296.74	\$272.41	\$346.07	\$318.24	\$348.49	\$324.15	\$280.32	\$261.32
85	\$242.32	\$223.74	\$302.57	\$277.74	\$354.32	\$325.82	\$361.57	\$336.40	\$292.15	\$272.32
86	\$243.91	\$225.16	\$307.07	\$281.91	\$361.40	\$332.32	\$375.23	\$349.07	\$304.49	\$283.82
87	\$245.49	\$226.57	\$311.74	\$286.07	\$366.82	\$337.32	\$389.32	\$362.24	\$317.40	\$295.82
88	\$246.99	\$228.07	\$316.40	\$290.41	\$372.32	\$342.40	\$403.98	\$375.82	\$330.82	\$308.32
89	\$248.57	\$229.49	\$321.15	\$294.74	\$377.90	\$347.49	\$419.23	\$389.98	\$344.74	\$321.40
90+	\$250.16	\$230.99	\$325.99	\$299.15	\$383.57	\$352.74	\$435.07	\$404.73	\$359.32	\$334.99
Under Age 65	\$204.24	\$188.58	N/A							

DISCLOSURES

Questions? We're here to help.

Just call us at 1-800-345-6022
(TTY: 711)

Use this outline to compare benefits and premiums 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 Aetna Life Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Aetna Life Insurance Company, PO Box 1188, Brentwood, TN, 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 of 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

This policy may not fully cover all of your medical costs. Neither Aetna 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.**

PLAN A
Medicare (Part A) – Hospital Services – Per Benefit Period

Services	Medicare Pays	Plan A	
		Plan Pays	You Pay
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,260	\$0	\$1,260 (Part A deductible)
61st thru 90th day	All but \$315 a day	\$315 a day	\$0
91st day and after:			
▪ While using 60 lifetime reserve days	All but \$630 a day	\$630 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 \$157.50 a day	\$0	Up to \$157.50 a day
101st day and after	\$0	\$0	All costs

*A **Benefit Period** begins on the first day you receive care 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.

****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 (continued)
Medicare (Part A) – Hospital Services – Per Benefit Period

Services	Medicare Pays	Plan A	
		Plan Pays	You Pay
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 a very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

PLAN A
Medicare (Part B) – Medical Services – Per Calendar Year

Services	Medicare Pays	Plan A	
		Plan Pays	You Pay
MEDICAL EXPENSES			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENTS , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, 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

*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.

PLAN A (continued)
Medicare (Part B) – Medical Services – Per Calendar Year

Services	Medicare Pays	Plan A	
		Plan Pays	You Pay
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 A	
		Plan Pays	You Pay
HOME HEALTH CARE			
Medicare-Approved Services			
<ul style="list-style-type: none"> ▪ Medically necessary skilled care services and medical supplies 	100%	\$0	\$0
<ul style="list-style-type: none"> ▪ Durable medical equipment: <ul style="list-style-type: none"> - First \$147 of Medicare-approved amounts* - Remainder of Medicare-approved amounts 	\$0 80%	\$0 20%	\$147 (Part B deductible) \$0

*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.

PLAN B
Medicare (Part A) – Hospital Services – Per Benefit Period

Services	Medicare Pays	Plan B	
		Plan Pays	You Pay
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,260	\$1,260 (Part A deductible)	\$0
61 st thru 90 th day	All but \$315 a day	\$315 a day	\$0
91 st day and after:			
▪ While using 60 lifetime reserve days	All but \$630 a day	\$630 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
21 st thru 100 th day	All but \$157.50 a day	\$0	Up to \$157.50 a day
101 st day and after	\$0	\$0	All costs

*A **Benefit Period** begins on the first day you receive care 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.

****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 (continued)
Medicare (Part A) – Hospital Services – Per Benefit Period

Services	Medicare Pays	Plan B	
		Plan Pays	You Pay
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

PLAN B
Medicare (Part B) – Medical Services – Per Calendar Year

Services	Medicare Pays	Plan B	
		Plan Pays	You Pay
MEDICAL EXPENSES			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENTS , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, 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

*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.

PLAN B (continued)
Medicare (Part B) – Medical Services – Per Calendar Year

Services	Medicare Pays	Plan B	
		Plan Pays	You Pay
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 B	
		Plan Pays	You Pay
HOME HEALTH CARE			
Medicare-Approved Services			
<ul style="list-style-type: none"> ▪ Medically necessary skilled care services and medical supplies 	100%	\$0	\$0
<ul style="list-style-type: none"> ▪ Durable medical equipment: <ul style="list-style-type: none"> - First \$147 of Medicare-approved amounts* - Remainder of Medicare-approved amounts 	\$0	\$0	\$147 (Part B deductible)
	80%	20%	\$0

*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.

PLAN F
Medicare (Part A) – Hospital Services – Per Benefit Period

Services	Medicare Pays	Plan F	
		Plan Pays	You Pay
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,260	\$1,260 (Part A deductible)	\$0
61st thru 90th day	All but \$315 a day	\$315 a day	\$0
91st day and after:			
▪ While using 60 lifetime reserve days	All but \$630 a day	\$630 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 \$157.50 a day	Up to \$157.50 a day	\$0
101st day and after	\$0	\$0	All costs

*A **Benefit Period** begins on the first day you receive care 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.

****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 (continued)
Medicare (Part A) – Hospital Services – Per Benefit Period

Services	Medicare Pays	Plan F	
		Plan Pays	You Pay
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

PLAN F
Medicare (Part B) – Medical Services – Per Calendar Year

Services	Medicare Pays	Plan F	
		Plan Pays	You Pay
MEDICAL EXPENSES			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENTS , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, 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% of all costs	\$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

*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.

PLAN F (continued)
Medicare (Part B) – Medical Services – Per Calendar Year

Services	Medicare Pays	Plan F	
		Plan Pays	You Pay
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

Services	Medicare Pays	Plan F	
		Plan Pays	You Pay
HOME HEALTH CARE			
Medicare-Approved Services			
<ul style="list-style-type: none"> ▪ Medically necessary skilled care services and medical supplies 	100%	\$0	\$0
<ul style="list-style-type: none"> ▪ Durable medical equipment: <ul style="list-style-type: none"> - First \$147 of Medicare-approved amounts* - Remainder of Medicare-approved amounts 	\$0 80%	\$147 (Part B deductible) 20%	\$0 \$0

OTHER BENEFITS – Not Covered by Medicare

Services	Medicare Pays	Plan F	
		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 such charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

*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.

PLAN G
Medicare (Part A) – Hospital Services – Per Benefit Period

Services	Medicare Pays	Plan G	
		Plan Pays	You Pay
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: <ul style="list-style-type: none"> ▪ While using 60 lifetime reserve days ▪ Once lifetime reserve days are used: <ul style="list-style-type: none"> -Additional 365 days -Beyond the additional 365 days 	All but \$1,260 All but \$315 a day All but \$630 a day \$0 \$0	\$1,260 (Part A deductible) \$315 a day \$630 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21st thru 100th day 101st day and after	All approved amounts All but \$157.50 a day \$0	\$0 Up to \$157.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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

*A **Benefit Period** begins on the first day you receive care 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.

****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

Services	Medicare Pays	Plan G	
		Plan Pays	You Pay
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENTS , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$147 of Medicare-approved amounts* Remainder of Medicare-approved amounts Part B Excess Charges (above Medicare-approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% 100% of all costs	\$147 (Part B deductible) \$0 \$0
BLOOD First 3 pints Next \$147 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$147 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES Tests for diagnostic services	100%	\$0	\$0

*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.

**PLAN G
PARTS A & B**

Services	Medicare Pays	Plan G	
		Plan Pays	You Pay
HOME HEALTH CARE Medicare-Approved Services <ul style="list-style-type: none"> ▪ Medically necessary skilled care services and medical supplies ▪ Durable medical equipment: <ul style="list-style-type: none"> - First \$147 of Medicare-approved amounts* - Remainder of Medicare-approved amounts 	100%	\$0	\$0
	\$0	\$0	\$147 (Part B deductible)
	80%	20%	\$0

OTHER BENEFITS – Not Covered by Medicare

Services	Medicare Pays	Plan G	
		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 Remainder of such charges	\$0	\$0	\$250
	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

*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.

PLAN N
Medicare (Part A) – Hospital Services – Per Benefit Period

Services	Medicare Pays	Plan N	
		Plan Pays	You Pay
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: <ul style="list-style-type: none"> ▪ While using 60 lifetime reserve days ▪ Once lifetime reserve days are used: <ul style="list-style-type: none"> -Additional 365 days -Beyond the additional 365 days 	All but \$1,260 All but \$315 a day All but \$630 a day \$0 \$0	\$1,260 (Part A deductible) \$315 a day \$630 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21st thru 100th day 101st day and after	All approved amounts All but \$157.50 a day \$0	\$0 Up to \$157.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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

*A **Benefit Period** begins on the first day you receive care 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.

****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

Services	Medicare Pays	Plan N	
		Plan Pays	You Pay
MEDICAL EXPENSES			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENTS , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, 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 co-payment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$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

*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.

**PLAN N
PARTS A & B**

Services	Medicare Pays	Plan N	
		Plan Pays	You Pay
HOME HEALTH CARE			
Medicare-Approved Services			
<ul style="list-style-type: none"> ▪ Medically necessary skilled care services and medical supplies 	100%	\$0	\$0
<ul style="list-style-type: none"> ▪ Durable medical equipment: <ul style="list-style-type: none"> - First \$147 of Medicare-approved amounts* - Remainder of Medicare-approved amounts 	\$0	\$0	\$147 (Part B Deductible)
	80%	20%	\$0

OTHER BENEFITS – Not Covered by Medicare

Services	Medicare Pays	Plan N	
		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 such charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

*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.