Aetna Life Insurance Company
Outline of Medicare Supplement Coverage

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. 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 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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Outline of Medicare Supplement Coverage

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

*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,140 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,140. 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.

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. Aetna will send a written notice at least 31 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

The rates in the table below apply to the following **ZIP CODES: 77000** through **77099; 77200** through **77799**

	PLAN A		PLAN B		PLAN C		PLAN F		PLAN G		PLAN N	
Attained Age	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	$142.28	$131.37	$158.36	$145.38	$178.24	$163.90	$178.46	$164.09	$162.66	$151.34	$123.27	$114.91
66	$147.61	$136.30	$164.30	$150.82	$184.93	$170.05	$185.15	$170.24	$170.45	$158.60	$129.33	$120.56
67	$152.95	$141.21	$170.23	$156.27	$191.60	$176.18	$191.83	$176.38	$178.25	$165.85	$135.37	$126.19
68	$159.13	$146.92	$178.10	$163.49	$200.67	$184.53	$200.91	$184.73	$186.02	$173.09	$141.41	$131.83
69	$165.29	$152.61	$185.94	$170.67	$209.70	$192.82	$209.94	$193.04	$193.78	$180.30	$147.44	$137.45
70	$171.42	$158.26	$193.75	$177.84	$218.70	$201.11	$218.94	$201.32	$201.51	$187.51	$153.44	$143.05
71	$177.53	$163.90	$201.54	$184.99	$227.68	$209.35	$227.91	$209.56	$209.25	$194.70	$159.45	$148.64
72	$183.60	$169.51	$209.28	$192.10	$236.60	$217.56	$236.84	$217.77	$216.95	$201.87	$165.42	$154.21
73	$187.80	$173.38	$215.83	$198.10	$244.34	$224.67	$244.58	$224.89	$225.52	$209.83	$172.19	$160.53
74	$191.95	$177.21	$222.30	$204.04	$252.01	$231.72	$252.24	$231.93	$234.01	$217.75	$178.92	$166.79
75	$196.08	$181.02	$228.78	$209.99	$259.68	$238.78	$259.91	$238.99	$242.50	$225.64	$185.65	$173.06
76	$200.23	$184.85	$235.26	$215.95	$267.34	$245.83	$267.58	$246.04	$250.98	$233.54	$192.36	$179.30
77	$204.34	$188.64	$241.70	$221.86	$274.98	$252.86	$275.21	$253.06	$259.43	$241.40	$199.04	$185.53
78	$207.34	$191.41	$246.13	$225.94	$280.54	$257.97	$280.75	$258.16	$266.60	$248.07	$204.95	$191.04
79	$210.25	$194.09	$250.47	$229.91	$286.01	$262.98	$286.21	$263.17	$273.69	$254.67	$210.79	$196.48
80	$213.06	$196.69	$254.70	$233.80	$291.34	$267.88	$291.53	$268.07	$280.70	$261.20	$216.58	$201.88
81	$215.78	$199.20	$258.97	$237.73	$296.74	$272.84	$296.91	$273.01	$287.76	$267.76	$222.40	$207.31
82	$218.38	$201.59	$263.23	$241.63	$302.11	$277.78	$302.27	$277.94	$294.79	$274.31	$228.21	$212.72
83	$220.10	$203.18	$268.29	$246.28	$309.34	$284.43	$309.47	$284.56	$308.75	$287.29	$240.19	$223.88
84	$221.72	$204.67	$273.36	$250.93	$316.57	$291.07	$316.66	$291.17	$322.72	$300.30	$252.18	$235.07
85	$223.29	$206.12	$278.67	$255.81	$324.13	$298.01	$324.18	$298.09	$334.89	$311.62	$262.84	$245.02
86	$224.72	$207.42	$282.85	$259.64	$330.62	$303.98	$330.67	$304.05	$347.51	$323.35	$273.96	$255.37
87	$226.14	$208.75	$287.10	$263.54	$335.58	$308.53	$335.62	$308.61	$360.61	$335.52	$285.53	$266.17
88	$227.59	$210.07	$291.42	$267.49	$340.61	$313.17	$340.66	$313.23	$374.21	$348.17	$297.60	$277.42
89	$229.04	$211.41	$295.79	$271.51	$345.72	$317.87	$345.77	$317.93	$388.32	$361.30	$310.20	$289.15
90+	$230.49	$212.76	$300.23	$275.57	$350.90	$322.63	$350.94	$322.70	$402.95	$374.91	$323.29	$301.38
Enrolled When Under Age 65 and Disabled												
Under 65	$798.46	$798.46	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65 & Older	$798.46	$798.46	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

MONTHLY PREMIUMS

The rates in the table below apply to the following **ZIP CODES: 75000** through **75499; 75700** through **75799; 76000** through **76299; 76400** through **76499**

	PLAN A		PLAN B		PLAN C		PLAN F		PLAN G		PLAN N	
Attained Age	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	$135.17	$124.80	$150.44	$138.11	$169.33	$155.71	$169.54	$155.89	$154.53	$143.77	$117.11	$109.16
66	$140.23	$129.49	$156.09	$143.28	$175.68	$161.55	$175.89	$161.73	$161.93	$150.67	$122.86	$114.53
67	$145.30	$134.15	$161.72	$148.46	$182.02	$167.37	$182.24	$167.56	$169.34	$157.56	$128.60	$119.88
68	$151.17	$139.57	$169.20	$155.32	$190.64	$175.30	$190.86	$175.49	$176.72	$164.44	$134.34	$125.24
69	$157.03	$144.98	$176.64	$162.14	$199.22	$183.18	$199.44	$183.39	$184.09	$171.29	$140.07	$130.58
70	$162.85	$150.35	$184.06	$168.95	$207.77	$191.05	$207.99	$191.25	$191.43	$178.13	$145.77	$135.90
71	$168.65	$155.71	$191.46	$175.74	$216.30	$198.88	$216.51	$199.08	$198.79	$184.97	$151.48	$141.21
72	$174.42	$161.03	$198.82	$182.50	$224.77	$206.68	$225.00	$206.88	$206.10	$191.78	$157.15	$146.50
73	$178.41	$164.71	$205.04	$188.20	$232.12	$213.44	$232.35	$213.65	$214.24	$199.34	$163.58	$152.50
74	$182.35	$168.35	$211.19	$193.84	$239.41	$220.13	$239.63	$220.33	$222.31	$206.86	$169.97	$158.45
75	$186.28	$171.97	$217.34	$199.49	$246.70	$226.84	$246.91	$227.04	$230.38	$214.36	$176.37	$164.41
76	$190.22	$175.61	$223.50	$205.15	$253.97	$233.54	$254.20	$233.74	$238.43	$221.86	$182.74	$170.34
77	$194.12	$179.21	$229.62	$210.77	$261.23	$240.22	$261.45	$240.41	$246.46	$229.33	$189.09	$176.25
78	$196.97	$181.84	$233.82	$214.64	$266.51	$245.07	$266.71	$245.25	$253.27	$235.67	$194.70	$181.49
79	$199.74	$184.39	$237.95	$218.41	$271.71	$249.83	$271.90	$250.01	$260.01	$241.94	$200.25	$186.66
80	$202.41	$186.86	$241.97	$222.11	$276.77	$254.49	$276.95	$254.67	$266.67	$248.14	$205.75	$191.79
81	$204.99	$189.24	$246.02	$225.84	$281.90	$259.20	$282.06	$259.36	$273.37	$254.37	$211.28	$196.94
82	$207.46	$191.51	$250.07	$229.55	$287.00	$263.89	$287.16	$264.04	$280.05	$260.59	$216.80	$202.08
83	$209.10	$193.02	$254.88	$233.97	$293.87	$270.21	$294.00	$270.33	$293.31	$272.93	$228.18	$212.69
84	$210.63	$194.44	$259.69	$238.38	$300.74	$276.52	$300.83	$276.61	$306.58	$285.29	$239.57	$223.32
85	$212.13	$195.81	$264.74	$243.02	$307.92	$283.11	$307.97	$283.19	$318.15	$296.04	$249.70	$232.77
86	$213.48	$197.05	$268.71	$246.66	$314.09	$288.78	$314.14	$288.85	$330.13	$307.18	$260.26	$242.60
87	$214.83	$198.31	$272.75	$250.36	$318.80	$293.10	$318.84	$293.18	$342.58	$318.74	$271.25	$252.86
88	$216.21	$199.57	$276.85	$254.12	$323.58	$297.51	$323.63	$297.57	$355.50	$330.76	$282.72	$263.55
89	$217.59	$200.84	$281.00	$257.93	$328.43	$301.98	$328.48	$302.03	$368.90	$343.24	$294.69	$274.69
90+	$218.97	$202.12	$285.22	$261.79	$333.36	$306.50	$333.39	$306.57	$382.80	$356.16	$307.13	$286.31
Enrolled When Under Age 65 and Disabled												
Under 65	$758.54	$758.54	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65 & Older	$758.54	$758.54	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

MONTHLY PREMIUMS

The rates in the table below apply to all other **ZIP CODES** in the state

	PLAN A		PLAN B		PLAN C		PLAN F		PLAN G		PLAN N	
Attained Age	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
65	$128.05	$118.23	$142.52	$130.84	$160.42	$147.51	$160.61	$147.68	$146.39	$136.21	$110.94	$103.42
66	$132.85	$122.67	$147.87	$135.74	$166.44	$153.05	$166.64	$153.22	$153.41	$142.74	$116.40	$108.50
67	$137.66	$127.09	$153.21	$140.64	$172.44	$158.56	$172.65	$158.74	$160.43	$149.27	$121.83	$113.57
68	$143.22	$132.23	$160.29	$147.14	$180.60	$166.08	$180.82	$166.26	$167.42	$155.78	$127.27	$118.65
69	$148.76	$137.35	$167.35	$153.60	$188.73	$173.54	$188.95	$173.74	$174.40	$162.27	$132.70	$123.71
70	$154.28	$142.43	$174.38	$160.06	$196.83	$181.00	$197.05	$181.19	$181.36	$168.76	$138.10	$128.75
71	$159.78	$147.51	$181.39	$166.49	$204.91	$188.42	$205.12	$188.60	$188.33	$175.23	$143.51	$133.78
72	$165.24	$152.56	$188.35	$172.89	$212.94	$195.80	$213.16	$195.99	$195.26	$181.68	$148.88	$138.79
73	$169.02	$156.04	$194.25	$178.29	$219.91	$202.20	$220.12	$202.40	$202.97	$188.85	$154.97	$144.48
74	$172.76	$159.49	$200.07	$183.64	$226.81	$208.55	$227.02	$208.74	$210.61	$195.98	$161.03	$150.11
75	$176.47	$162.92	$205.90	$188.99	$233.71	$214.90	$233.92	$215.09	$218.25	$203.08	$167.09	$155.75
76	$180.21	$166.37	$211.73	$194.36	$240.61	$221.25	$240.82	$221.44	$225.88	$210.19	$173.12	$161.37
77	$183.91	$169.78	$217.53	$199.67	$247.48	$227.57	$247.69	$227.75	$233.49	$217.26	$179.14	$166.98
78	$186.61	$172.27	$221.52	$203.35	$252.49	$232.17	$252.68	$232.34	$239.94	$223.26	$184.46	$171.94
79	$189.23	$174.68	$225.42	$206.92	$257.41	$236.68	$257.59	$236.85	$246.32	$229.20	$189.71	$176.83
80	$191.75	$177.02	$229.23	$210.42	$262.21	$241.09	$262.38	$241.26	$252.63	$235.08	$194.92	$181.69
81	$194.20	$179.28	$233.07	$213.96	$267.07	$245.56	$267.22	$245.71	$258.98	$240.98	$200.16	$186.58
82	$196.54	$181.43	$236.91	$217.47	$271.90	$250.00	$272.04	$250.15	$265.31	$246.88	$205.39	$191.45
83	$198.09	$182.86	$241.46	$221.65	$278.41	$255.99	$278.52	$256.10	$277.88	$258.56	$216.17	$201.49
84	$199.55	$184.20	$246.02	$225.84	$284.91	$261.96	$284.99	$262.05	$290.45	$270.27	$226.96	$211.56
85	$200.96	$185.51	$250.80	$230.23	$291.72	$268.21	$291.76	$268.28	$301.40	$280.46	$236.56	$220.52
86	$202.25	$186.68	$254.57	$233.68	$297.56	$273.58	$297.60	$273.65	$312.76	$291.02	$246.56	$229.83
87	$203.53	$187.88	$258.39	$237.19	$302.02	$277.68	$302.06	$277.75	$324.55	$301.97	$256.98	$239.55
88	$204.83	$189.06	$262.28	$240.74	$306.55	$281.85	$306.59	$281.91	$336.79	$313.35	$267.84	$249.68
89	$206.14	$190.27	$266.21	$244.36	$311.15	$286.08	$311.19	$286.14	$349.49	$325.17	$279.18	$260.24
90+	$207.44	$191.48	$270.21	$248.01	$315.81	$290.37	$315.85	$290.43	$362.66	$337.42	$290.96	$271.24
Enrolled When Under Age 65 and Disabled												
Under 65	$718.61	$718.61	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65 & Older	$718.61	$718.61	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	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.

EXCLUSIONS AND LIMITATIONS

This policy may not fully cover all of your medical costs. Certain exclusions and limitations apply based upon your Medicare coverage.

(continued on next page)

DISCLOSURES

Questions? We're here to help.

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

In addition, this policy contains a Pre-Existing Conditions Limitation. This policy does not pay benefits for loss which occurs within six months after the effective date of your coverage as a result of a pre-existing condition. A pre-existing condition is a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage. Please note that pre-existing conditions will be covered after 6 months from the effective date of coverage. This exclusion does not apply to loss which occurs more than six months after the effective date of coverage.

If you apply for this policy during the 6 month period beginning with the first of the month in which you are eligible, and as of the date you apply you had a continuous period of **Creditable Coverage** of at least 6 months the pre-existing conditions limitation will not apply to you. If you apply for this policy during the 6-month period beginning with the first of the month in which you are eligible, and as of the date you apply you had a continuous period of Creditable Coverage of less than 6 months, the pre-existing conditions limitation will be reduced by the aggregate of the period of Creditable Coverage applicable as of your enrollment date.

If this policy is issued to replace another Medicare supplement policy as a result of certain situations involving health coverage changes, the pre-existing conditions exclusion will not be applied. Some of these situations include: personal choice; loss of the policyholder's group coverage; termination of a Medicare Advantage program under which you were covered; termination of coverage because you moved out of the plan's service area; the insurance company that provided you Medicare Supplement coverage went out of business, or committed fraud.

REFUND OF PREMIUM

The policy includes a provision describing the Refund of Premium in certain circumstances. If the insured dies or if the policy is cancelled, Aetna will refund any part of the premiums paid which applies to the period after the date of death of the insured or the date of cancellation.

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 $1,216	$0	$1,216 (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 a day	$0	Up to $152 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			
INPATIENT OR OUTPATIENT HOSPITAL TREATMENT, 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			
▪ 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

*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 $1,216	$1,216 (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 a day	$0	Up to $152 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 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			
INPATIENT OR OUTPATIENT HOSPITAL TREATMENT, 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			
▪ 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

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

Services	Medicare Pays	Plan C	
		Plan Pays	You Pay
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,216	$1,216 (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 a day	Up to $152 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 C (continued)
Medicare (Part A) – Hospital Services – Per Benefit Period

Services	Medicare Pays	Plan C	
		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 C
Medicare (Part B) – Medical Services – Per Calendar Year

Services	Medicare Pays	Plan C	
		Plan Pays	You Pay
MEDICAL EXPENSES			
INPATIENT OR OUTPATIENT HOSPITAL TREATMENT, 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	$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 C (continued)

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

Services	Medicare Pays	Plan C	
		Plan Pays	You Pay
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 C	
		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

OTHER BENEFITS – Not Covered by Medicare

Services	Medicare Pays	Plan C	
		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 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 $1,216	$1,216 (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 a day	Up to $152 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			
INPATIENT OR OUTPATIENT HOSPITAL TREATMENT, 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%	$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			
▪ 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	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	All but $1,216	$1,216 (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 a day	Up to $152 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

*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*	$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% of all costs	$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

*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 (continued)
PARTS A & B

Services	Medicare Pays	Plan G	
		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 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	$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 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	All but $1,216	$1,216 (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 a day	Up to $152 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

*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 (continued)
PARTS A & B

Services	Medicare Pays	Plan N	
		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 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.