aetna®

Aetna Health and Life Insurance Company

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Outline of Coverage

Medicare Supplement Insurance

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

Underwritten by

Aetna Health and Life Insurance Company

Mississippi

Rates Effective: 02/2019 A

AETNA HEALTH AND LIFE INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE
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.

See Outlines of Coverage Sections 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, 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 $5560; paid at 100% after limit reached	Out-of-pocket limit $2780; 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 $2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2300. 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 Premiums

For Use in ZIP Codes: 394-395

Female Rates

Rates Effective 02/1/2019

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,041	4,477	5,660	2,264	4,481	3,779
65	1,293	1,431	1,810	724	1,283	1,087
66	1,293	1,431	1,810	724	1,283	1,087
67	1,293	1,431	1,810	724	1,283	1,087
68	1,308	1,449	1,832	733	1,299	1,100
69	1,337	1,480	1,871	748	1,326	1,124
70	1,371	1,519	1,921	768	1,361	1,154
71	1,412	1,565	1,979	791	1,403	1,188
72	1,456	1,614	2,039	815	1,445	1,225
73	1,504	1,665	2,107	842	1,493	1,265
74	1,557	1,725	2,180	872	1,546	1,310
75	1,614	1,788	2,261	904	1,602	1,357
76	1,670	1,850	2,339	936	1,658	1,406
77	1,727	1,913	2,418	967	1,714	1,452
78	1,782	1,976	2,496	999	1,769	1,500
79	1,841	2,039	2,578	1,032	1,827	1,550
80	1,899	2,103	2,659	1,064	1,885	1,598
81	1,959	2,170	2,743	1,098	1,944	1,648
82	2,020	2,237	2,828	1,132	2,005	1,698
83	2,082	2,307	2,916	1,167	2,067	1,751
84	2,146	2,377	3,005	1,202	2,130	1,806
85	2,221	2,461	3,111	1,244	2,204	1,868
86	2,285	2,531	3,200	1,279	2,267	1,921
87	2,350	2,603	3,289	1,316	2,332	1,976
88	2,416	2,675	3,381	1,353	2,397	2,032
89	2,482	2,749	3,475	1,390	2,464	2,087
90	2,550	2,825	3,572	1,429	2,531	2,145
91	2,619	2,902	3,669	1,469	2,600	2,203
92	2,690	2,980	3,768	1,507	2,671	2,263
93	2,762	3,058	3,868	1,548	2,741	2,323
94	2,835	3,139	3,970	1,588	2,814	2,385
95	2,908	3,221	4,073	1,630	2,886	2,448
96	2,984	3,304	4,179	1,671	2,962	2,510
97	3,061	3,390	4,286	1,714	3,038	2,574
98	3,138	3,475	4,393	1,758	3,114	2,639
99+	3,215	3,562	4,503	1,802	3,192	2,705

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,489	4,975	6,290	2,515	4,979	4,198
65	1,436	1,591	2,011	805	1,425	1,208
66	1,436	1,591	2,011	805	1,425	1,208
67	1,436	1,591	2,011	805	1,425	1,208
68	1,453	1,609	2,035	813	1,443	1,223
69	1,485	1,643	2,079	832	1,473	1,249
70	1,524	1,687	2,134	854	1,511	1,283
71	1,570	1,739	2,198	879	1,559	1,321
72	1,618	1,793	2,266	905	1,606	1,362
73	1,671	1,850	2,341	936	1,659	1,406
74	1,730	1,916	2,423	969	1,717	1,455
75	1,793	1,987	2,511	1,005	1,780	1,509
76	1,856	2,056	2,599	1,040	1,841	1,561
77	1,918	2,125	2,686	1,075	1,904	1,614
78	1,980	2,195	2,773	1,110	1,966	1,667
79	2,046	2,266	2,864	1,146	2,030	1,722
80	2,110	2,336	2,955	1,181	2,094	1,775
81	2,176	2,411	3,048	1,220	2,160	1,830
82	2,244	2,486	3,143	1,257	2,228	1,888
83	2,313	2,563	3,241	1,296	2,297	1,946
84	2,384	2,641	3,340	1,337	2,367	2,006
85	2,468	2,734	3,456	1,383	2,450	2,076
86	2,539	2,812	3,555	1,422	2,520	2,134
87	2,610	2,891	3,654	1,462	2,592	2,196
88	2,683	2,972	3,758	1,503	2,663	2,257
89	2,758	3,054	3,861	1,546	2,738	2,320
90	2,834	3,139	3,969	1,587	2,813	2,384
91	2,911	3,224	4,076	1,631	2,889	2,450
92	2,989	3,311	4,186	1,675	2,968	2,515
93	3,069	3,398	4,298	1,719	3,046	2,581
94	3,149	3,488	4,411	1,764	3,126	2,649
95	3,232	3,579	4,527	1,811	3,208	2,719
96	3,317	3,672	4,643	1,857	3,291	2,789
97	3,400	3,766	4,761	1,904	3,375	2,860
98	3,487	3,861	4,882	1,954	3,461	2,933
99+	3,573	3,958	5,004	2,002	3,546	3,005

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

The above rates do not include the $6 one-time policy fee.

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

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

Aetna Health and Life Insurance Company

Annual Premiums

For Use in ZIP Codes: 394-395

Male Rates

Rates Effective 02/1/2019

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,648	5,149	6,510	2,605	5,154	4,345
65	1,486	1,646	2,081	833	1,474	1,251
66	1,486	1,646	2,081	833	1,474	1,251
67	1,486	1,646	2,081	833	1,474	1,251
68	1,504	1,665	2,107	842	1,493	1,265
69	1,538	1,702	2,152	860	1,525	1,293
70	1,576	1,747	2,209	883	1,564	1,328
71	1,624	1,800	2,276	910	1,612	1,366
72	1,675	1,856	2,346	938	1,663	1,410
73	1,729	1,915	2,423	968	1,717	1,455
74	1,791	1,983	2,508	1,002	1,778	1,506
75	1,856	2,056	2,600	1,040	1,841	1,561
76	1,921	2,127	2,690	1,077	1,905	1,617
77	1,986	2,199	2,780	1,112	1,971	1,670
78	2,049	2,272	2,870	1,150	2,035	1,725
79	2,118	2,346	2,965	1,186	2,101	1,782
80	2,185	2,419	3,057	1,223	2,167	1,837
81	2,253	2,496	3,155	1,263	2,235	1,895
82	2,323	2,573	3,253	1,301	2,306	1,954
83	2,395	2,653	3,354	1,342	2,377	2,015
84	2,468	2,734	3,456	1,383	2,450	2,077
85	2,554	2,830	3,577	1,431	2,536	2,148
86	2,628	2,911	3,680	1,472	2,608	2,209
87	2,702	2,993	3,783	1,514	2,681	2,273
88	2,778	3,076	3,889	1,555	2,757	2,335
89	2,855	3,161	3,996	1,599	2,834	2,400
90	2,933	3,249	4,107	1,643	2,911	2,468
91	3,012	3,336	4,219	1,689	2,990	2,534
92	3,093	3,427	4,333	1,734	3,071	2,603
93	3,177	3,517	4,448	1,780	3,153	2,672
94	3,259	3,610	4,566	1,826	3,235	2,742
95	3,345	3,704	4,685	1,874	3,320	2,814
96	3,433	3,801	4,806	1,922	3,407	2,886
97	3,520	3,898	4,928	1,971	3,494	2,959
98	3,609	3,996	5,053	2,022	3,582	3,035
99+	3,698	4,096	5,179	2,072	3,671	3,111

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	5,163	5,720	7,233	2,892	5,727	4,827
65	1,650	1,829	2,312	926	1,639	1,389
66	1,650	1,829	2,312	926	1,639	1,389
67	1,650	1,829	2,312	926	1,639	1,389
68	1,671	1,850	2,340	936	1,660	1,406
69	1,708	1,890	2,391	956	1,694	1,436
70	1,752	1,940	2,454	982	1,738	1,474
71	1,805	2,001	2,527	1,011	1,792	1,519
72	1,861	2,061	2,606	1,042	1,847	1,566
73	1,922	2,127	2,693	1,077	1,907	1,617
74	1,990	2,203	2,787	1,114	1,975	1,674
75	2,061	2,285	2,888	1,156	2,046	1,735
76	2,134	2,364	2,989	1,196	2,118	1,795
77	2,207	2,444	3,090	1,236	2,189	1,856
78	2,277	2,523	3,189	1,276	2,261	1,916
79	2,353	2,606	3,295	1,318	2,334	1,979
80	2,427	2,686	3,398	1,359	2,409	2,042
81	2,503	2,773	3,506	1,403	2,484	2,104
82	2,581	2,859	3,614	1,447	2,561	2,170
83	2,660	2,948	3,727	1,491	2,641	2,239
84	2,742	3,038	3,840	1,538	2,721	2,308
85	2,839	3,144	3,974	1,591	2,817	2,388
86	2,919	3,233	4,089	1,636	2,899	2,454
87	3,002	3,324	4,203	1,682	2,980	2,525
88	3,086	3,418	4,321	1,728	3,062	2,596
89	3,171	3,512	4,440	1,778	3,148	2,668
90	3,258	3,610	4,564	1,825	3,234	2,741
91	3,347	3,708	4,687	1,876	3,322	2,816
92	3,438	3,808	4,814	1,926	3,413	2,892
93	3,530	3,907	4,942	1,978	3,504	2,968
94	3,622	4,012	5,073	2,030	3,594	3,047
95	3,717	4,116	5,205	2,082	3,688	3,126
96	3,814	4,223	5,339	2,135	3,784	3,207
97	3,911	4,332	5,475	2,190	3,882	3,289
98	4,011	4,440	5,614	2,246	3,980	3,372
99+	4,109	4,552	5,754	2,302	4,079	3,456

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

The above rates do not include the $6 one-time policy fee.

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

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

Aetna Health and Life Insurance Company

Annual Premiums

For Use in: Rest of State

Female Rates

Rates Effective 02/1/2019

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,674	4,070	5,145	2,058	4,074	3,435
65	1,175	1,301	1,645	658	1,166	988
66	1,175	1,301	1,645	658	1,166	988
67	1,175	1,301	1,645	658	1,166	988
68	1,189	1,317	1,665	666	1,181	1,000
69	1,215	1,345	1,701	680	1,205	1,022
70	1,246	1,381	1,746	698	1,237	1,049
71	1,284	1,423	1,799	719	1,275	1,080
72	1,324	1,467	1,854	741	1,314	1,114
73	1,367	1,514	1,915	765	1,357	1,150
74	1,415	1,568	1,982	793	1,405	1,191
75	1,467	1,625	2,055	822	1,456	1,234
76	1,518	1,682	2,126	851	1,507	1,278
77	1,570	1,739	2,198	879	1,558	1,320
78	1,620	1,796	2,269	908	1,608	1,364
79	1,674	1,854	2,344	938	1,661	1,409
80	1,726	1,912	2,417	967	1,714	1,453
81	1,781	1,973	2,494	998	1,767	1,498
82	1,836	2,034	2,571	1,029	1,823	1,544
83	1,893	2,097	2,651	1,061	1,879	1,592
84	1,951	2,161	2,732	1,093	1,936	1,642
85	2,019	2,237	2,828	1,131	2,004	1,698
86	2,077	2,301	2,909	1,163	2,061	1,746
87	2,136	2,366	2,990	1,196	2,120	1,796
88	2,196	2,432	3,074	1,230	2,179	1,847
89	2,256	2,499	3,159	1,264	2,240	1,897
90	2,318	2,568	3,247	1,299	2,301	1,950
91	2,381	2,638	3,335	1,335	2,364	2,003
92	2,445	2,709	3,425	1,370	2,428	2,057
93	2,511	2,780	3,516	1,407	2,492	2,112
94	2,577	2,854	3,609	1,444	2,558	2,168
95	2,644	2,928	3,703	1,482	2,624	2,225
96	2,713	3,004	3,799	1,519	2,693	2,282
97	2,783	3,082	3,896	1,558	2,762	2,340
98	2,853	3,159	3,994	1,598	2,831	2,399
99+	2,923	3,238	4,094	1,638	2,902	2,459

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,081	4,523	5,718	2,286	4,526	3,816
65	1,305	1,446	1,828	732	1,295	1,098
66	1,305	1,446	1,828	732	1,295	1,098
67	1,305	1,446	1,828	732	1,295	1,098
68	1,321	1,463	1,850	739	1,312	1,112
69	1,350	1,494	1,890	756	1,339	1,135
70	1,385	1,534	1,940	776	1,374	1,166
71	1,427	1,581	1,998	799	1,417	1,201
72	1,471	1,630	2,060	823	1,460	1,238
73	1,519	1,682	2,128	851	1,508	1,278
74	1,573	1,742	2,203	881	1,561	1,323
75	1,630	1,806	2,283	914	1,618	1,372
76	1,687	1,869	2,363	945	1,674	1,419
77	1,744	1,932	2,442	977	1,731	1,467
78	1,800	1,995	2,521	1,009	1,787	1,515
79	1,860	2,060	2,604	1,042	1,845	1,565
80	1,918	2,124	2,686	1,074	1,904	1,614
81	1,978	2,192	2,771	1,109	1,964	1,664
82	2,040	2,260	2,857	1,143	2,025	1,716
83	2,103	2,330	2,946	1,178	2,088	1,769
84	2,167	2,401	3,036	1,215	2,152	1,824
85	2,244	2,485	3,142	1,257	2,227	1,887
86	2,308	2,556	3,232	1,293	2,291	1,940
87	2,373	2,628	3,322	1,329	2,356	1,996
88	2,439	2,702	3,416	1,366	2,421	2,052
89	2,507	2,776	3,510	1,405	2,489	2,109
90	2,576	2,854	3,608	1,443	2,557	2,167
91	2,646	2,931	3,705	1,483	2,626	2,227
92	2,717	3,010	3,805	1,523	2,698	2,286
93	2,790	3,089	3,907	1,563	2,769	2,346
94	2,863	3,171	4,010	1,604	2,842	2,408
95	2,938	3,254	4,115	1,646	2,916	2,472
96	3,015	3,338	4,221	1,688	2,992	2,535
97	3,091	3,424	4,328	1,731	3,068	2,600
98	3,170	3,510	4,438	1,776	3,146	2,666
99+	3,248	3,598	4,549	1,820	3,224	2,732

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

The above rates do not include the $6 one-time policy fee.

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

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

Aetna Health and Life Insurance Company

Annual Premiums

For Use in: Rest of State

Male Rates

Rates Effective 02/1/2019

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,225	4,681	5,918	2,368	4,685	3,950
65	1,351	1,496	1,892	757	1,340	1,137
66	1,351	1,496	1,892	757	1,340	1,137
67	1,351	1,496	1,892	757	1,340	1,137
68	1,367	1,514	1,915	765	1,357	1,150
69	1,398	1,547	1,956	782	1,386	1,175
70	1,433	1,588	2,008	803	1,422	1,207
71	1,476	1,636	2,069	827	1,465	1,242
72	1,523	1,687	2,133	853	1,512	1,282
73	1,572	1,741	2,203	880	1,561	1,323
74	1,628	1,803	2,280	911	1,616	1,369
75	1,687	1,869	2,364	945	1,674	1,419
76	1,746	1,934	2,445	979	1,732	1,470
77	1,805	1,999	2,527	1,011	1,792	1,518
78	1,863	2,065	2,609	1,045	1,850	1,568
79	1,925	2,133	2,695	1,078	1,910	1,620
80	1,986	2,199	2,779	1,112	1,970	1,670
81	2,048	2,269	2,868	1,148	2,032	1,723
82	2,112	2,339	2,957	1,183	2,096	1,776
83	2,177	2,412	3,049	1,220	2,161	1,832
84	2,244	2,485	3,142	1,257	2,227	1,888
85	2,322	2,573	3,252	1,301	2,305	1,953
86	2,389	2,646	3,345	1,338	2,371	2,008
87	2,456	2,721	3,439	1,376	2,437	2,066
88	2,525	2,796	3,535	1,414	2,506	2,123
89	2,595	2,874	3,633	1,454	2,576	2,182
90	2,666	2,954	3,734	1,494	2,646	2,244
91	2,738	3,033	3,835	1,535	2,718	2,304
92	2,812	3,115	3,939	1,576	2,792	2,366
93	2,888	3,197	4,044	1,618	2,866	2,429
94	2,963	3,282	4,151	1,660	2,941	2,493
95	3,041	3,367	4,259	1,704	3,018	2,558
96	3,121	3,455	4,369	1,747	3,097	2,624
97	3,200	3,544	4,480	1,792	3,176	2,690
98	3,281	3,633	4,594	1,838	3,256	2,759
99+	3,362	3,724	4,708	1,884	3,337	2,828

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,694	5,200	6,575	2,629	5,206	4,388
65	1,500	1,663	2,102	842	1,490	1,263
66	1,500	1,663	2,102	842	1,490	1,263
67	1,500	1,663	2,102	842	1,490	1,263
68	1,519	1,682	2,127	851	1,509	1,278
69	1,553	1,718	2,174	869	1,540	1,305
70	1,593	1,764	2,231	893	1,580	1,340
71	1,641	1,819	2,297	919	1,629	1,381
72	1,692	1,874	2,369	947	1,679	1,424
73	1,747	1,934	2,448	979	1,734	1,470
74	1,809	2,003	2,534	1,013	1,795	1,522
75	1,874	2,077	2,625	1,051	1,860	1,577
76	1,940	2,149	2,717	1,087	1,925	1,632
77	2,006	2,222	2,809	1,124	1,990	1,687
78	2,070	2,294	2,899	1,160	2,055	1,742
79	2,139	2,369	2,995	1,198	2,122	1,799
80	2,206	2,442	3,089	1,235	2,190	1,856
81	2,275	2,521	3,187	1,275	2,258	1,913
82	2,346	2,599	3,285	1,315	2,328	1,973
83	2,418	2,680	3,388	1,355	2,401	2,035
84	2,493	2,762	3,491	1,398	2,474	2,098
85	2,581	2,858	3,613	1,446	2,561	2,171
86	2,654	2,939	3,717	1,487	2,635	2,231
87	2,729	3,022	3,821	1,529	2,709	2,295
88	2,805	3,107	3,928	1,571	2,784	2,360
89	2,883	3,193	4,036	1,616	2,862	2,425
90	2,962	3,282	4,149	1,659	2,940	2,492
91	3,043	3,371	4,261	1,705	3,020	2,560
92	3,125	3,462	4,376	1,751	3,103	2,629
93	3,209	3,552	4,493	1,798	3,185	2,698
94	3,293	3,647	4,612	1,845	3,267	2,770
95	3,379	3,742	4,732	1,893	3,353	2,842
96	3,467	3,839	4,854	1,941	3,440	2,915
97	3,555	3,938	4,977	1,991	3,529	2,990
98	3,646	4,036	5,104	2,042	3,618	3,065
99+	3,735	4,138	5,231	2,093	3,708	3,142

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

The above rates do not include the $6 one-time policy fee.

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

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

PREMIUM INFORMATION

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

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

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

DISCLOSURES

Use this outline to compare benefits and premium among policies.

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 an 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; and (c) be someone with whom you have continuously resided for the past 12 months. The household discount will only be applicable if a policy for each applicant is issued. The discounted rate will be 7 percent lower than the individual rates.

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 14770, Lexington, KY 40512-4770. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

POLICY REPLACEMENT

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

NOTICE

The policy may not cover all of your medical costs.

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER 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 $1364	$0	$1364 (Part A Deductible)
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	$0	Up to $170.50 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 $185 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 tests, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	$0	Up to $170.50 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 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 $185 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 tests, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 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 $185 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 tests, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$185 (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 PLAN F

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

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

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2300. 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 $2300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2300 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 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 $185 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 $2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2300. 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 $2300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2300 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 tests, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$185 (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 $2300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2300 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $185 of Medicare Approved amounts*	$0	$185 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2300 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2300 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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 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 $185 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 tests, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 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 $185 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 tests, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (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