



Outline of coverage

Medicare Supplement Insurance

Benefit Plans A, B, F, G, High Deductible G, N

Illinois

Underwritten by

Aetna Health Insurance Company

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AETNA HEALTH INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE
BENEFIT PLANS AVAILABLE: A, B, F, G, HIGH DEDUCTIBLE G, N

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and High Deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G ¹	K	L	M	N	C	F ¹
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply ³	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2026 ²					\$8,000²	\$4,000²				

¹ Plans F and G also have a high deductible option, which require first paying a plan deductible of **\$2,950** before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

² Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

³ Plan N pays 100% of the Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that do not result in an inpatient admission.

Aetna Health Insurance Company
 Annual premiums
 For use in ZIP Codes: 600-608
 Female rates
 Rates effective 04/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	5,259	6,119	9,324	7,774	1,725	5,554
65	2,118	2,462	3,752	3,126	695	2,113
66	2,118	2,462	3,752	3,126	695	2,113
67	2,118	2,462	3,752	3,126	695	2,113
68	2,140	2,489	3,794	3,162	703	2,191
69	2,188	2,546	3,883	3,231	719	2,280
70	2,246	2,612	3,979	3,320	737	2,365
71	2,315	2,692	4,100	3,419	759	2,448
72	2,385	2,775	4,230	3,525	783	2,531
73	2,465	2,865	4,369	3,641	809	2,617
74	2,551	2,967	4,522	3,767	837	2,704
75	2,641	3,070	4,678	3,899	866	2,795
76	2,732	3,178	4,843	4,038	897	2,884
77	2,828	3,290	5,011	4,177	928	2,980
78	2,924	3,403	5,184	4,322	960	3,078
79	3,017	3,508	5,346	4,456	989	3,179
80	3,109	3,617	5,510	4,593	1,021	3,286
81	3,208	3,733	5,689	4,739	1,053	3,387
82	3,303	3,843	5,855	4,882	1,083	3,487
83	3,403	3,962	6,037	5,032	1,117	3,595
84	3,503	4,077	6,214	5,181	1,150	3,700
85	3,634	4,225	6,438	5,368	1,192	3,834
86	3,735	4,345	6,622	5,521	1,225	3,946
87	3,841	4,470	6,810	5,677	1,260	4,057
88	3,949	4,595	7,004	5,839	1,296	4,174
89	4,061	4,722	7,196	5,998	1,332	4,285
90	4,171	4,855	7,393	6,165	1,369	4,404
91	4,285	4,986	7,596	6,331	1,405	4,523
92	4,402	5,119	7,802	6,500	1,443	4,645
93	4,519	5,257	8,006	6,676	1,482	4,771
94	4,638	5,395	8,218	6,852	1,521	4,895
95	4,757	5,536	8,435	7,030	1,561	5,023
96	4,882	5,678	8,651	7,213	1,602	5,152
97	5,004	5,824	8,872	7,397	1,642	5,287
98	5,132	5,970	9,095	7,582	1,683	5,417
99+	5,259	6,119	9,324	7,774	1,725	5,554

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	5,843	6,801	10,362	8,637	1,916	6,169
65	2,353	2,737	4,169	3,474	773	2,349
66	2,353	2,737	4,169	3,474	773	2,349
67	2,353	2,737	4,169	3,474	773	2,349
68	2,379	2,768	4,216	3,514	780	2,434
69	2,432	2,829	4,312	3,592	799	2,534
70	2,493	2,903	4,423	3,685	819	2,630
71	2,571	2,991	4,557	3,802	844	2,721
72	2,651	3,082	4,696	3,918	870	2,814
73	2,737	3,183	4,854	4,044	899	2,908
74	2,834	3,296	5,027	4,188	930	3,004
75	2,934	3,414	5,198	4,333	961	3,101
76	3,035	3,534	5,382	4,486	997	3,203
77	3,141	3,655	5,568	4,643	1,031	3,311
78	3,251	3,780	5,759	4,800	1,067	3,420
79	3,351	3,897	5,939	4,952	1,099	3,531
80	3,455	4,019	6,127	5,106	1,136	3,651
81	3,563	4,147	6,317	5,266	1,170	3,764
82	3,670	4,271	6,502	5,426	1,204	3,875
83	3,784	4,403	6,708	5,593	1,241	3,995
84	3,895	4,529	6,900	5,753	1,278	4,113
85	4,039	4,696	7,153	5,965	1,324	4,258
86	4,151	4,826	7,360	6,134	1,361	4,383
87	4,268	4,966	7,568	6,308	1,400	4,510
88	4,386	5,105	7,781	6,487	1,441	4,633
89	4,510	5,248	7,996	6,664	1,481	4,761
90	4,635	5,390	8,215	6,849	1,521	4,893
91	4,760	5,539	8,440	7,035	1,563	5,027
92	4,890	5,689	8,667	7,222	1,604	5,162
93	5,022	5,840	8,896	7,416	1,647	5,298
94	5,152	5,995	9,134	7,615	1,691	5,439
95	5,288	6,149	9,372	7,810	1,735	5,582
96	5,422	6,309	9,614	8,013	1,779	5,725
97	5,561	6,471	9,858	8,218	1,824	5,873
98	5,701	6,633	10,107	8,428	1,870	6,021
99+	5,843	6,801	10,362	8,637	1,916	6,169

The above rates do not include the \$20 one-time policy fee.

To calculate the 7% 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 periods, use preferred rates.

Modal factors

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

Aetna Health Insurance Company
 Annual premiums
 For use in ZIP Codes: 600-608
 Male rates
 Rates effective 04/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	6,050	7,036	10,723	8,940	1,982	6,384
65	2,435	2,835	4,313	3,600	799	2,430
66	2,435	2,835	4,313	3,600	799	2,430
67	2,435	2,835	4,313	3,600	799	2,430
68	2,462	2,863	4,362	3,640	808	2,517
69	2,514	2,928	4,466	3,719	827	2,623
70	2,584	3,003	4,578	3,817	848	2,724
71	2,662	3,094	4,716	3,933	872	2,817
72	2,745	3,190	4,863	4,056	900	2,913
73	2,834	3,296	5,024	4,188	930	3,013
74	2,934	3,414	5,200	4,333	961	3,112
75	3,036	3,534	5,382	4,486	997	3,213
76	3,141	3,654	5,568	4,643	1,031	3,314
77	3,252	3,783	5,766	4,805	1,067	3,428
78	3,362	3,913	5,961	4,968	1,104	3,536
79	3,468	4,033	6,147	5,124	1,138	3,655
80	3,574	4,159	6,341	5,287	1,174	3,778
81	3,690	4,296	6,541	5,453	1,211	3,894
82	3,801	4,421	6,730	5,614	1,247	4,012
83	3,917	4,557	6,943	5,790	1,285	4,135
84	4,028	4,689	7,144	5,954	1,322	4,257
85	4,177	4,860	7,403	6,173	1,371	4,411
86	4,296	4,996	7,616	6,348	1,409	4,538
87	4,418	5,140	7,832	6,528	1,449	4,666
88	4,541	5,281	8,053	6,713	1,491	4,799
89	4,671	5,430	8,274	6,898	1,532	4,927
90	4,796	5,580	8,506	7,088	1,574	5,065
91	4,927	5,734	8,735	7,283	1,616	5,204
92	5,062	5,886	8,970	7,477	1,659	5,344
93	5,198	6,045	9,205	7,675	1,704	5,487
94	5,332	6,204	9,451	7,875	1,748	5,628
95	5,470	6,365	9,697	8,086	1,796	5,776
96	5,610	6,529	9,949	8,295	1,841	5,925
97	5,755	6,697	10,202	8,507	1,887	6,078
98	5,901	6,866	10,462	8,720	1,936	6,228
99+	6,050	7,036	10,723	8,940	1,982	6,384

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	6,722	7,821	11,914	9,933	2,203	7,097
65	2,706	3,147	4,799	3,995	889	2,698
66	2,706	3,147	4,799	3,995	889	2,698
67	2,706	3,147	4,799	3,995	889	2,698
68	2,734	3,181	4,850	4,042	897	2,797
69	2,797	3,253	4,957	4,133	919	2,914
70	2,868	3,339	5,087	4,240	942	3,024
71	2,956	3,442	5,243	4,371	970	3,126
72	3,046	3,548	5,401	4,507	1,000	3,233
73	3,147	3,663	5,582	4,652	1,033	3,348
74	3,259	3,793	5,779	4,815	1,070	3,457
75	3,374	3,925	5,975	4,985	1,106	3,568
76	3,491	4,063	6,188	5,156	1,147	3,685
77	3,614	4,207	6,404	5,340	1,185	3,807
78	3,735	4,346	6,622	5,520	1,227	3,934
79	3,852	4,481	6,832	5,700	1,264	4,060
80	3,974	4,620	7,046	5,873	1,305	4,197
81	4,097	4,770	7,269	6,061	1,344	4,329
82	4,221	4,908	7,477	6,238	1,385	4,458
83	4,350	5,065	7,716	6,436	1,426	4,597
84	4,478	5,206	7,938	6,619	1,470	4,730
85	4,641	5,399	8,226	6,860	1,522	4,898
86	4,774	5,551	8,468	7,060	1,565	5,043
87	4,907	5,712	8,701	7,252	1,610	5,187
88	5,046	5,870	8,948	7,459	1,657	5,329
89	5,187	6,034	9,196	7,665	1,703	5,478
90	5,331	6,203	9,449	7,874	1,748	5,625
91	5,476	6,371	9,706	8,090	1,797	5,781
92	5,623	6,539	9,969	8,308	1,844	5,939
93	5,773	6,717	10,233	8,528	1,894	6,093
94	5,925	6,894	10,504	8,757	1,944	6,255
95	6,082	7,073	10,776	8,981	1,996	6,419
96	6,236	7,256	11,053	9,214	2,046	6,583
97	6,394	7,444	11,338	9,453	2,097	6,754
98	6,556	7,630	11,621	9,690	2,151	6,924
99+	6,722	7,821	11,914	9,933	2,203	7,097

The above rates do not include the \$20 one-time policy fee.

To calculate the 7% 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 periods, use preferred rates.

Modal factors

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

Aetna Health Insurance Company
 Annual premiums
 For use in: Rest of State
 Female rates
 Rates effective 04/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	4,738	5,513	8,400	7,004	1,554	5,004
65	1,908	2,218	3,380	2,816	626	1,904
66	1,908	2,218	3,380	2,816	626	1,904
67	1,908	2,218	3,380	2,816	626	1,904
68	1,928	2,242	3,418	2,849	633	1,974
69	1,971	2,294	3,498	2,911	648	2,054
70	2,023	2,353	3,585	2,991	664	2,131
71	2,086	2,425	3,694	3,080	684	2,205
72	2,149	2,500	3,811	3,176	705	2,280
73	2,221	2,581	3,936	3,280	729	2,358
74	2,298	2,673	4,074	3,394	754	2,436
75	2,379	2,766	4,214	3,513	780	2,518
76	2,461	2,863	4,363	3,638	808	2,598
77	2,548	2,964	4,514	3,763	836	2,685
78	2,634	3,066	4,670	3,894	865	2,773
79	2,718	3,160	4,816	4,014	891	2,864
80	2,801	3,259	4,964	4,138	920	2,960
81	2,890	3,363	5,125	4,269	949	3,051
82	2,976	3,462	5,275	4,398	976	3,141
83	3,066	3,569	5,439	4,533	1,006	3,239
84	3,156	3,673	5,598	4,668	1,036	3,333
85	3,274	3,806	5,800	4,836	1,074	3,454
86	3,365	3,914	5,966	4,974	1,104	3,555
87	3,460	4,027	6,135	5,114	1,135	3,655
88	3,558	4,140	6,310	5,260	1,168	3,760
89	3,659	4,254	6,483	5,404	1,200	3,860
90	3,758	4,374	6,660	5,554	1,233	3,968
91	3,860	4,492	6,843	5,704	1,266	4,075
92	3,966	4,612	7,029	5,856	1,300	4,185
93	4,071	4,736	7,213	6,014	1,335	4,298
94	4,178	4,860	7,404	6,173	1,370	4,410
95	4,286	4,987	7,599	6,333	1,406	4,525
96	4,398	5,115	7,794	6,498	1,443	4,641
97	4,508	5,247	7,993	6,664	1,479	4,763
98	4,623	5,378	8,194	6,831	1,516	4,880
99+	4,738	5,513	8,400	7,004	1,554	5,004

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	5,264	6,127	9,335	7,781	1,726	5,558
65	2,120	2,466	3,756	3,130	696	2,116
66	2,120	2,466	3,756	3,130	696	2,116
67	2,120	2,466	3,756	3,130	696	2,116
68	2,143	2,494	3,798	3,166	703	2,193
69	2,191	2,549	3,885	3,236	720	2,283
70	2,246	2,615	3,985	3,320	738	2,369
71	2,316	2,695	4,105	3,425	760	2,451
72	2,388	2,777	4,231	3,530	784	2,535
73	2,466	2,868	4,373	3,643	810	2,620
74	2,553	2,969	4,529	3,773	838	2,706
75	2,643	3,076	4,683	3,904	866	2,794
76	2,734	3,184	4,849	4,041	898	2,886
77	2,830	3,293	5,016	4,183	929	2,983
78	2,929	3,405	5,188	4,324	961	3,081
79	3,019	3,511	5,350	4,461	990	3,181
80	3,113	3,621	5,520	4,600	1,023	3,289
81	3,210	3,736	5,691	4,744	1,054	3,391
82	3,306	3,848	5,858	4,888	1,085	3,491
83	3,409	3,967	6,043	5,039	1,118	3,599
84	3,509	4,080	6,216	5,183	1,151	3,705
85	3,639	4,231	6,444	5,374	1,193	3,836
86	3,740	4,348	6,631	5,526	1,226	3,949
87	3,845	4,474	6,818	5,683	1,261	4,063
88	3,951	4,599	7,010	5,844	1,298	4,174
89	4,063	4,728	7,204	6,004	1,334	4,289
90	4,176	4,856	7,401	6,170	1,370	4,408
91	4,288	4,990	7,604	6,338	1,408	4,529
92	4,405	5,125	7,808	6,506	1,445	4,650
93	4,524	5,261	8,014	6,681	1,484	4,773
94	4,641	5,401	8,229	6,860	1,523	4,900
95	4,764	5,540	8,443	7,036	1,563	5,029
96	4,885	5,684	8,661	7,219	1,603	5,158
97	5,010	5,830	8,881	7,404	1,643	5,291
98	5,136	5,976	9,105	7,593	1,685	5,424
99+	5,264	6,127	9,335	7,781	1,726	5,558

The above rates do not include the \$20 one-time policy fee.

To calculate the 7% household discount:

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Modal premium x .93 = **discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

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

Aetna Health Insurance Company

Annual premiums

For use in: Rest of State

Male rates

Rates effective 04/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	5,450	6,339	9,660	8,054	1,786	5,751
65	2,194	2,554	3,886	3,243	720	2,189
66	2,194	2,554	3,886	3,243	720	2,189
67	2,194	2,554	3,886	3,243	720	2,189
68	2,218	2,579	3,930	3,279	728	2,268
69	2,265	2,638	4,023	3,350	745	2,363
70	2,328	2,705	4,124	3,439	764	2,454
71	2,398	2,787	4,249	3,543	786	2,538
72	2,473	2,874	4,381	3,654	811	2,624
73	2,553	2,969	4,526	3,773	838	2,714
74	2,643	3,076	4,685	3,904	866	2,804
75	2,735	3,184	4,849	4,041	898	2,895
76	2,830	3,292	5,016	4,183	929	2,986
77	2,930	3,408	5,195	4,329	961	3,088
78	3,029	3,525	5,370	4,476	995	3,186
79	3,124	3,633	5,538	4,616	1,025	3,293
80	3,220	3,747	5,713	4,763	1,058	3,404
81	3,324	3,870	5,893	4,913	1,091	3,508
82	3,424	3,983	6,063	5,058	1,123	3,614
83	3,529	4,105	6,255	5,216	1,158	3,725
84	3,629	4,224	6,436	5,364	1,191	3,835
85	3,763	4,378	6,669	5,561	1,235	3,974
86	3,870	4,501	6,861	5,719	1,269	4,088
87	3,980	4,631	7,056	5,881	1,305	4,204
88	4,091	4,758	7,255	6,048	1,343	4,323
89	4,208	4,892	7,454	6,214	1,380	4,439
90	4,321	5,027	7,663	6,386	1,418	4,563
91	4,439	5,166	7,869	6,561	1,456	4,688
92	4,560	5,303	8,081	6,736	1,495	4,814
93	4,683	5,446	8,293	6,914	1,535	4,943
94	4,804	5,589	8,514	7,095	1,575	5,070
95	4,928	5,734	8,736	7,285	1,618	5,204
96	5,054	5,882	8,963	7,473	1,659	5,338
97	5,185	6,033	9,191	7,664	1,700	5,476
98	5,316	6,186	9,425	7,856	1,744	5,611
99+	5,450	6,339	9,660	8,054	1,786	5,751

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	6,056	7,046	10,733	8,949	1,985	6,394
65	2,438	2,835	4,323	3,599	801	2,431
66	2,438	2,835	4,323	3,599	801	2,431
67	2,438	2,835	4,323	3,599	801	2,431
68	2,463	2,866	4,369	3,641	808	2,520
69	2,520	2,931	4,466	3,723	828	2,625
70	2,584	3,008	4,583	3,820	849	2,724
71	2,663	3,101	4,723	3,938	874	2,816
72	2,744	3,196	4,866	4,060	901	2,913
73	2,835	3,300	5,029	4,191	931	3,016
74	2,936	3,417	5,206	4,338	964	3,114
75	3,040	3,536	5,383	4,491	996	3,214
76	3,145	3,660	5,575	4,645	1,033	3,320
77	3,256	3,790	5,769	4,811	1,068	3,430
78	3,365	3,915	5,966	4,973	1,105	3,544
79	3,470	4,037	6,155	5,135	1,139	3,658
80	3,580	4,162	6,348	5,291	1,176	3,781
81	3,691	4,297	6,549	5,460	1,211	3,900
82	3,803	4,422	6,736	5,620	1,248	4,016
83	3,919	4,563	6,951	5,798	1,285	4,141
84	4,034	4,690	7,151	5,963	1,324	4,261
85	4,181	4,864	7,411	6,180	1,371	4,413
86	4,301	5,001	7,629	6,360	1,410	4,543
87	4,421	5,146	7,839	6,533	1,450	4,673
88	4,546	5,288	8,061	6,720	1,493	4,801
89	4,673	5,436	8,285	6,905	1,534	4,935
90	4,803	5,588	8,513	7,094	1,575	5,068
91	4,933	5,740	8,744	7,288	1,619	5,208
92	5,066	5,891	8,981	7,485	1,661	5,350
93	5,201	6,051	9,219	7,683	1,706	5,489
94	5,338	6,211	9,463	7,889	1,751	5,635
95	5,479	6,372	9,708	8,091	1,798	5,783
96	5,618	6,537	9,958	8,301	1,843	5,931
97	5,760	6,706	10,214	8,516	1,889	6,085
98	5,906	6,874	10,469	8,730	1,938	6,238
99+	6,056	7,046	10,733	8,949	1,985	6,394

The above rates do not include the \$20 one-time policy fee.

To calculate the 7% 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 periods, use preferred rates.

Modal factors

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

PREMIUM INFORMATION

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

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

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

HOUSEHOLD DISCOUNT

In order to be eligible for the Household discount under an Aetna Health 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 have a Medicare supplement policy with an Aetna company. The Medicare eligible adult must be either (a) your spouse or someone with whom you are in a civil union partnership; and (b) 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 rates will be 7 percent lower than the individual rates and will apply as long as both policies remain in force.

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Aetna Health Insurance Company, P.O. Box 14770, Lexington, Kentucky 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 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, G, HIGH DEDUCTIBLE G and N OFFERED BY AETNA HEALTH 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 \$1,736	\$0	\$1,736 (Part A Deductible)
61st thru 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$868 a day	\$868 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 \$217 a day	\$0	Up to \$217 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 \$283 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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$1,736	\$1,736 (Part A Deductible)	\$0
61st thru 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$868 a day	\$868 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 \$217 a day	\$0	Up to \$217 a day
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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

PLAN B

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

*Once you have been billed \$283 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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$1,736	\$1,736 (Part A Deductible)	\$0
61st thru 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$868 a day	\$868 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 \$217 a day	Up to \$217 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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

PLAN F

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

*Once you have been billed \$283 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 \$283 of Medicare-Approved amounts*	\$0	\$283 (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 \$283 of Medicare-Approved amounts*	\$0	\$283 (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 \$283 of Medicare-Approved amounts*	\$0	\$283 (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

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 \$1,736	\$1,736 (Part A Deductible)	\$0
61st thru 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$868 a day	\$868 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 \$217 a day	Up to \$217 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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

PLAN G

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

*Once you have been billed \$283 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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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

HIGH DEDUCTIBLE 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.

****This high deductible plan pays the same benefits as Plan G after one has paid a calendar year \$2,950 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are \$2,950. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan’s separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,950 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,950 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,736	\$1,736 (Part A Deductible)	\$0
61st thru 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$868 a day	\$868 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 \$217 a day	Up to \$217 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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

HIGH DEDUCTIBLE PLAN G

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

*Once you have been billed \$283 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 G after one has paid a calendar year \$2,950 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are \$2,950. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,950 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,950 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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (Unless Part B Deductible has been met)
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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,950 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,950 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,950 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,950 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 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 \$1,736	\$1,736 (Part A Deductible)	\$0
61st thru 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$868 a day	\$868 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 \$217 a day	Up to \$217 a day	\$0
101st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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

PLAN N

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

*Once you have been billed \$283 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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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