



Outline of coverage

Medicare Supplement Insurance

Benefit Plans: A, F, G, N

District of Columbia

Underwritten by

**Aetna Health and Life
Insurance Company**

[AetnaSeniorProducts.com](https://www.aetna.com/seniorproducts)

AETNA HEALTH AND LIFE INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE
BENEFIT PLANS AVAILABLE: A, F, 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 2025 ²					\$7,220 ²	\$3,610 ²				

¹ Plans F and G also have a high deductible option, which require first paying a plan deductible of **\$2,870** 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 and Life Insurance Company

Annual premiums

For use in: Entire State

Female rates

Rates effective 9/1/2024

ATTAINED AGE	PREFERRED			
	Plan A	Plan F	Plan G	Plan N
65	1,467	1,969	1,746	1,100
66	1,467	1,969	1,746	1,100
67	1,467	1,969	1,746	1,100
68	1,486	1,995	1,770	1,143
69	1,517	2,035	1,805	1,186
70	1,554	2,086	1,850	1,231
71	1,603	2,152	1,909	1,275
72	1,657	2,222	1,970	1,320
73	1,712	2,298	2,037	1,366
74	1,772	2,378	2,110	1,412
75	1,835	2,462	2,184	1,459
76	1,899	2,548	2,259	1,506
77	1,962	2,635	2,336	1,553
78	2,030	2,724	2,416	1,606
79	2,097	2,812	2,495	1,659
80	2,162	2,901	2,573	1,714
81	2,226	2,988	2,650	1,767
82	2,294	3,077	2,728	1,818
83	2,364	3,172	2,813	1,874
84	2,437	3,269	2,900	1,932
85	2,518	3,377	2,995	1,997
86	2,589	3,475	3,082	2,053
87	2,663	3,573	3,169	2,112
88	2,737	3,673	3,257	2,170
89	2,813	3,775	3,348	2,231
90	2,891	3,880	3,440	2,292
91	2,969	3,985	3,534	2,354
92	3,049	4,092	3,629	2,418
93	3,131	4,201	3,726	2,483
94	3,213	4,312	3,824	2,548
95	3,297	4,424	3,924	2,615
96	3,383	4,539	4,026	2,682
97	3,468	4,654	4,127	2,751
98	3,556	4,772	4,232	2,820
99+	3,645	4,892	4,338	2,891

ATTAINED AGE	STANDARD			
	Plan A	Plan F	Plan G	Plan N
65	1,630	2,188	1,939	1,222
66	1,630	2,188	1,939	1,222
67	1,630	2,188	1,939	1,222
68	1,652	2,218	1,967	1,271
69	1,686	2,262	2,005	1,318
70	1,727	2,318	2,055	1,367
71	1,781	2,390	2,120	1,417
72	1,840	2,468	2,189	1,466
73	1,902	2,553	2,264	1,518
74	1,969	2,642	2,344	1,571
75	2,038	2,735	2,426	1,620
76	2,110	2,831	2,510	1,673
77	2,180	2,926	2,596	1,726
78	2,255	3,026	2,684	1,783
79	2,330	3,125	2,772	1,844
80	2,402	3,222	2,859	1,904
81	2,473	3,320	2,945	1,962
82	2,548	3,420	3,032	2,020
83	2,627	3,524	3,126	2,082
84	2,707	3,632	3,221	2,146
85	2,797	3,752	3,329	2,219
86	2,877	3,861	3,424	2,280
87	2,958	3,969	3,521	2,346
88	3,042	4,081	3,619	2,412
89	3,126	4,194	3,719	2,479
90	3,211	4,310	3,821	2,547
91	3,298	4,428	3,927	2,616
92	3,388	4,546	4,033	2,686
93	3,478	4,668	4,139	2,758
94	3,571	4,792	4,249	2,831
95	3,663	4,916	4,359	2,905
96	3,759	5,044	4,473	2,980
97	3,853	5,171	4,586	3,057
98	3,952	5,302	4,703	3,134
99+	4,049	5,435	4,820	3,211

The above rates do not include the \$20 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 periods, use Preferred rates.

Modal factors

Semi-annual0.5200

Quarterly0.2650

Monthly.....0.0833

Aetna Health and Life Insurance Company

Annual premiums
For use in: Entire State
Male rates

Rates effective 9/1/2024

ATTAINED AGE	PREFERRED			
	Plan A	Plan F	Plan G	Plan N
65	1,687	2,265	2,008	1,266
66	1,687	2,265	2,008	1,266
67	1,687	2,265	2,008	1,266
68	1,709	2,295	2,035	1,315
69	1,745	2,340	2,076	1,364
70	1,788	2,399	2,127	1,415
71	1,844	2,475	2,195	1,466
72	1,904	2,555	2,266	1,518
73	1,969	2,642	2,343	1,572
74	2,038	2,735	2,426	1,625
75	2,110	2,831	2,510	1,676
76	2,184	2,930	2,598	1,731
77	2,257	3,029	2,686	1,786
78	2,334	3,133	2,779	1,847
79	2,411	3,234	2,869	1,909
80	2,486	3,335	2,959	1,971
81	2,561	3,436	3,048	2,032
82	2,638	3,539	3,137	2,091
83	2,718	3,649	3,235	2,155
84	2,802	3,760	3,334	2,222
85	2,895	3,884	3,445	2,296
86	2,978	3,996	3,544	2,362
87	3,062	4,109	3,645	2,429
88	3,147	4,224	3,746	2,496
89	3,235	4,342	3,850	2,565
90	3,324	4,462	3,956	2,636
91	3,413	4,583	4,065	2,708
92	3,507	4,707	4,172	2,781
93	3,599	4,831	4,283	2,856
94	3,695	4,959	4,397	2,930
95	3,792	5,089	4,511	3,007
96	3,890	5,220	4,630	3,084
97	3,989	5,353	4,747	3,164
98	4,090	5,488	4,866	3,243
99+	4,192	5,625	4,989	3,324

ATTAINED AGE	STANDARD			
	Plan A	Plan F	Plan G	Plan N
65	1,876	2,517	2,231	1,406
66	1,876	2,517	2,231	1,406
67	1,876	2,517	2,231	1,406
68	1,900	2,551	2,262	1,461
69	1,938	2,600	2,307	1,515
70	1,987	2,666	2,364	1,573
71	2,048	2,750	2,439	1,629
72	2,116	2,839	2,518	1,686
73	2,188	2,936	2,604	1,746
74	2,265	3,038	2,695	1,806
75	2,344	3,145	2,790	1,863
76	2,426	3,256	2,886	1,925
77	2,507	3,365	2,985	1,984
78	2,594	3,480	3,087	2,050
79	2,679	3,594	3,188	2,120
80	2,762	3,706	3,287	2,190
81	2,844	3,818	3,387	2,257
82	2,930	3,933	3,486	2,323
83	3,021	4,054	3,595	2,395
84	3,112	4,178	3,704	2,467
85	3,216	4,315	3,828	2,552
86	3,309	4,441	3,937	2,622
87	3,402	4,564	4,049	2,698
88	3,498	4,693	4,161	2,773
89	3,595	4,824	4,277	2,850
90	3,693	4,957	4,395	2,929
91	3,793	5,092	4,517	3,009
92	3,896	5,228	4,638	3,090
93	4,001	5,368	4,760	3,171
94	4,106	5,510	4,886	3,256
95	4,213	5,654	5,014	3,341
96	4,322	5,800	5,144	3,428
97	4,431	5,947	5,275	3,516
98	4,544	6,097	5,408	3,604
99+	4,656	6,251	5,543	3,693

The above rates do not include the \$20 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 periods, use Preferred rates.

Modal factors

Semi-annual0.5200
Quarterly0.2650
Monthly0.0833

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.

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 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 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, 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 \$1,676	\$0	\$1,676 (Part A Deductible)
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$838 a day	\$838 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 \$209.50 a day	\$0	Up to \$209.50 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 \$257 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 \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (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 \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (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 \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (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 \$1,676	\$1,676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$838 a day	\$838 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 \$209.50 a day	Up to \$209.50 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 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 \$257 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 \$257 of Medicare-Approved amounts*	\$0	\$257 (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 \$257 of Medicare-Approved amounts*	\$0	\$257 (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 \$257 of Medicare-Approved amounts*	\$0	\$257 (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 \$1,676	\$1,676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$838 a day	\$838 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 \$209.50 a day	Up to \$209.50 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 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 \$257 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 \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (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 \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (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 \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (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 \$1,676	\$1,676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$838 a day	\$838 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 \$209.50 a day	Up to \$209.50 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 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 \$257 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 \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (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 \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (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 \$257 of Medicare-Approved amounts*	\$0	\$0	\$257 (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