Outline of coverage

Medicare Supplement Insurance

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

Colorado

Underwritten by

Aetna Health Insurance Company

AetnaSeniorProducts.com

AHCMS05034CO

Rates effective: 08/2026 A

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

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

In Colorado, it is a requirement that all plans offered by Aetna Health Insurance Company are available to under age 65 Medicare qualified individuals.

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]					**$8,000**[2]	**$4,000**[2]				

[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: 800-802
Female rates

Rates effective 8/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,106	4,456	7,493	1,120	5,676	3,484
65	2,739	2,972	4,998	746	3,780	2,323
66	2,739	2,972	4,998	746	3,780	2,323
67	2,739	2,972	4,998	746	3,780	2,323
68	2,766	3,005	5,049	755	3,825	2,407
69	2,824	3,066	5,162	773	3,908	2,502
70	2,897	3,145	5,287	791	4,001	2,592
71	2,988	3,244	5,451	814	4,129	2,688
72	3,083	3,340	5,626	842	4,259	2,781
73	3,184	3,453	5,809	869	4,397	2,874
74	3,288	3,572	6,004	897	4,547	2,967
75	3,408	3,700	6,222	931	4,711	3,071
76	3,529	3,828	6,441	962	4,875	3,165
77	3,654	3,962	6,667	998	5,047	3,270
78	3,778	4,101	6,893	1,029	5,218	3,382
79	3,900	4,231	7,120	1,066	5,390	3,495
80	4,023	4,366	7,338	1,097	5,560	3,610
81	4,147	4,504	7,576	1,133	5,735	3,727
82	4,276	4,645	7,809	1,168	5,917	3,842
83	4,413	4,790	8,050	1,203	6,095	3,961
84	4,547	4,934	8,298	1,241	6,283	4,083
85	4,699	5,102	8,574	1,283	6,490	4,218
86	4,834	5,244	8,820	1,320	6,674	4,337
87	4,966	5,391	9,066	1,356	6,865	4,461
88	5,109	5,543	9,323	1,394	7,057	4,586
89	5,250	5,699	9,581	1,434	7,258	4,711
90	5,393	5,855	9,843	1,472	7,456	4,842
91	5,542	6,017	10,115	1,513	7,657	4,973
92	5,690	6,175	10,389	1,553	7,863	5,108
93	5,841	6,343	10,665	1,593	8,072	5,244
94	5,999	6,510	10,945	1,637	8,283	5,383
95	6,154	6,678	11,231	1,678	8,502	5,523
96	6,314	6,849	11,524	1,723	8,727	5,668
97	6,474	7,029	11,815	1,767	8,945	5,813
98	6,639	7,205	12,117	1,811	9,174	5,961
99+	6,806	7,385	12,414	1,858	9,402	6,108

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,565	4,955	8,327	1,244	6,305	3,870
65	3,043	3,304	5,552	831	4,207	2,582
66	3,043	3,304	5,552	831	4,207	2,582
67	3,043	3,304	5,552	831	4,207	2,582
68	3,074	3,337	5,609	841	4,249	2,676
69	3,136	3,408	5,734	858	4,343	2,781
70	3,219	3,492	5,875	879	4,444	2,882
71	3,318	3,605	6,058	905	4,589	2,987
72	3,423	3,715	6,248	936	4,730	3,092
73	3,536	3,836	6,453	965	4,885	3,192
74	3,654	3,966	6,672	998	5,047	3,300
75	3,786	4,109	6,914	1,034	5,233	3,408
76	3,921	4,254	7,156	1,071	5,416	3,519
77	4,060	4,405	7,406	1,107	5,606	3,634
78	4,196	4,553	7,660	1,145	5,798	3,757
79	4,334	4,702	7,910	1,182	5,989	3,885
80	4,469	4,852	8,154	1,220	6,181	4,013
81	4,612	5,005	8,412	1,258	6,374	4,140
82	4,753	5,163	8,677	1,297	6,569	4,270
83	4,900	5,320	8,945	1,338	6,773	4,401
84	5,049	5,481	9,219	1,379	6,979	4,536
85	5,218	5,666	9,521	1,425	7,209	4,687
86	5,369	5,830	9,800	1,467	7,420	4,818
87	5,523	5,992	10,075	1,507	7,629	4,956
88	5,674	6,159	10,358	1,549	7,847	5,096
89	5,832	6,329	10,649	1,592	8,058	5,238
90	5,998	6,504	10,940	1,636	8,282	5,382
91	6,157	6,684	11,241	1,679	8,504	5,527
92	6,323	6,864	11,544	1,724	8,738	5,678
93	6,491	7,046	11,849	1,772	8,970	5,829
94	6,661	7,233	12,162	1,819	9,204	5,982
95	6,838	7,423	12,481	1,866	9,447	6,136
96	7,013	7,614	12,803	1,915	9,694	6,294
97	7,192	7,806	13,129	1,962	9,942	6,459
98	7,377	8,005	13,459	2,013	10,193	6,622
99+	7,559	8,205	13,797	2,063	10,447	6,785

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: 800-802
Male rates

Rates effective 8/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,722	5,129	8,621	1,287	6,523	4,006
65	3,150	3,417	5,744	858	4,351	2,671
66	3,150	3,417	5,744	858	4,351	2,671
67	3,150	3,417	5,744	858	4,351	2,671
68	3,184	3,453	5,812	869	4,399	2,767
69	3,249	3,529	5,933	887	4,493	2,879
70	3,332	3,615	6,083	910	4,602	2,981
71	3,435	3,730	6,272	937	4,747	3,094
72	3,541	3,847	6,468	967	4,896	3,197
73	3,659	3,971	6,674	999	5,056	3,306
74	3,783	4,105	6,905	1,033	5,224	3,413
75	3,920	4,254	7,156	1,071	5,416	3,529
76	4,058	4,405	7,406	1,106	5,605	3,642
77	4,202	4,561	7,663	1,147	5,809	3,762
78	4,344	4,715	7,928	1,184	6,001	3,891
79	4,487	4,865	8,186	1,225	6,198	4,018
80	4,626	5,023	8,444	1,264	6,394	4,153
81	4,772	5,181	8,708	1,301	6,594	4,284
82	4,920	5,340	8,982	1,344	6,801	4,419
83	5,069	5,508	9,256	1,384	7,012	4,554
84	5,230	5,674	9,543	1,427	7,222	4,691
85	5,403	5,868	9,859	1,475	7,464	4,851
86	5,555	6,032	10,139	1,518	7,677	4,987
87	5,713	6,204	10,429	1,561	7,893	5,129
88	5,874	6,377	10,723	1,603	8,119	5,273
89	6,035	6,552	11,019	1,649	8,341	5,417
90	6,205	6,734	11,321	1,694	8,572	5,566
91	6,374	6,917	11,631	1,739	8,807	5,718
92	6,546	7,105	11,949	1,785	9,045	5,876
93	6,719	7,290	12,259	1,832	9,282	6,032
94	6,894	7,482	12,592	1,881	9,532	6,192
95	7,078	7,682	12,916	1,931	9,779	6,349
96	7,258	7,881	13,249	1,982	10,033	6,518
97	7,446	8,080	13,586	2,032	10,288	6,687
98	7,633	8,286	13,934	2,083	10,550	6,852
99+	7,825	8,492	14,278	2,136	10,806	7,022

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	5,250	5,699	9,576	1,431	7,253	4,450
65	3,502	3,800	6,385	954	4,831	2,966
66	3,502	3,800	6,385	954	4,831	2,966
67	3,502	3,800	6,385	954	4,831	2,966
68	3,536	3,836	6,457	966	4,887	3,078
69	3,610	3,920	6,591	988	4,992	3,197
70	3,705	4,017	6,759	1,010	5,113	3,312
71	3,818	4,146	6,965	1,041	5,277	3,434
72	3,936	4,273	7,187	1,077	5,440	3,553
73	4,066	4,414	7,422	1,109	5,619	3,674
74	4,202	4,563	7,674	1,147	5,809	3,795
75	4,352	4,728	7,953	1,191	6,022	3,920
76	4,510	4,896	8,230	1,231	6,227	4,045
77	4,667	5,064	8,518	1,276	6,452	4,179
78	4,824	5,238	8,808	1,316	6,668	4,321
79	4,982	5,408	9,091	1,362	6,886	4,468
80	5,139	5,581	9,384	1,401	7,105	4,616
81	5,303	5,755	9,677	1,446	7,328	4,761
82	5,467	5,936	9,978	1,492	7,555	4,910
83	5,633	6,118	10,288	1,537	7,789	5,062
84	5,807	6,303	10,605	1,585	8,024	5,216
85	6,001	6,519	10,953	1,639	8,292	5,389
86	6,174	6,702	11,271	1,685	8,532	5,543
87	6,348	6,892	11,587	1,733	8,770	5,696
88	6,525	7,083	11,916	1,783	9,024	5,859
89	6,710	7,281	12,247	1,831	9,272	6,022
90	6,893	7,479	12,583	1,880	9,521	6,188
91	7,081	7,684	12,925	1,932	9,781	6,356
92	7,272	7,892	13,278	1,983	10,050	6,527
93	7,464	8,100	13,623	2,035	10,317	6,702
94	7,663	8,317	13,984	2,092	10,586	6,877
95	7,864	8,536	14,351	2,146	10,864	7,057
96	8,068	8,758	14,724	2,204	11,145	7,243
97	8,275	8,979	15,097	2,255	11,431	7,427
98	8,481	9,207	15,482	2,314	11,717	7,615
99+	8,693	9,436	15,864	2,373	12,012	7,803

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 8/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,634	3,943	6,631	991	5,023	3,083
65	2,424	2,630	4,423	660	3,345	2,056
66	2,424	2,630	4,423	660	3,345	2,056
67	2,424	2,630	4,423	660	3,345	2,056
68	2,448	2,659	4,468	668	3,385	2,130
69	2,499	2,713	4,568	684	3,458	2,214
70	2,564	2,783	4,679	700	3,541	2,294
71	2,644	2,871	4,824	720	3,654	2,379
72	2,728	2,956	4,979	745	3,769	2,461
73	2,818	3,056	5,141	769	3,891	2,543
74	2,910	3,161	5,313	794	4,024	2,626
75	3,016	3,274	5,506	824	4,169	2,718
76	3,123	3,388	5,700	851	4,314	2,801
77	3,234	3,506	5,900	883	4,466	2,894
78	3,343	3,629	6,100	911	4,618	2,993
79	3,451	3,744	6,301	943	4,770	3,093
80	3,560	3,864	6,494	971	4,920	3,195
81	3,670	3,986	6,704	1,003	5,075	3,298
82	3,784	4,111	6,911	1,034	5,236	3,400
83	3,905	4,239	7,124	1,065	5,394	3,505
84	4,024	4,366	7,343	1,098	5,560	3,613
85	4,158	4,515	7,588	1,135	5,743	3,733
86	4,278	4,641	7,805	1,168	5,906	3,838
87	4,395	4,771	8,023	1,200	6,075	3,948
88	4,521	4,905	8,250	1,234	6,245	4,058
89	4,646	5,043	8,479	1,269	6,423	4,169
90	4,773	5,181	8,711	1,303	6,598	4,285
91	4,904	5,325	8,951	1,339	6,776	4,401
92	5,035	5,465	9,194	1,374	6,958	4,520
93	5,169	5,613	9,438	1,410	7,143	4,641
94	5,309	5,761	9,686	1,449	7,330	4,764
95	5,446	5,910	9,939	1,485	7,524	4,888
96	5,588	6,061	10,198	1,525	7,723	5,016
97	5,729	6,220	10,456	1,564	7,916	5,144
98	5,875	6,376	10,723	1,603	8,119	5,275
99+	6,023	6,535	10,986	1,644	8,320	5,405

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,040	4,385	7,369	1,101	5,580	3,425
65	2,693	2,924	4,913	735	3,723	2,285
66	2,693	2,924	4,913	735	3,723	2,285
67	2,693	2,924	4,913	735	3,723	2,285
68	2,720	2,953	4,964	744	3,760	2,368
69	2,775	3,016	5,074	759	3,843	2,461
70	2,849	3,090	5,199	778	3,933	2,550
71	2,936	3,190	5,361	801	4,061	2,643
72	3,029	3,288	5,529	828	4,186	2,736
73	3,129	3,395	5,711	854	4,323	2,825
74	3,234	3,510	5,904	883	4,466	2,920
75	3,350	3,636	6,119	915	4,631	3,016
76	3,470	3,765	6,333	948	4,793	3,114
77	3,593	3,898	6,554	980	4,961	3,216
78	3,713	4,029	6,779	1,013	5,131	3,325
79	3,835	4,161	7,000	1,046	5,300	3,438
80	3,955	4,294	7,216	1,080	5,470	3,551
81	4,081	4,429	7,444	1,113	5,641	3,664
82	4,206	4,569	7,679	1,148	5,813	3,779
83	4,336	4,708	7,916	1,184	5,994	3,895
84	4,468	4,850	8,158	1,220	6,176	4,014
85	4,618	5,014	8,426	1,261	6,380	4,148
86	4,751	5,159	8,673	1,298	6,566	4,264
87	4,888	5,303	8,916	1,334	6,751	4,386
88	5,021	5,450	9,166	1,371	6,944	4,510
89	5,161	5,601	9,424	1,409	7,131	4,635
90	5,308	5,756	9,681	1,448	7,329	4,763
91	5,449	5,915	9,948	1,486	7,526	4,891
92	5,596	6,074	10,216	1,526	7,733	5,025
93	5,744	6,235	10,486	1,568	7,938	5,158
94	5,895	6,401	10,763	1,610	8,145	5,294
95	6,051	6,569	11,045	1,651	8,360	5,430
96	6,206	6,738	11,330	1,695	8,579	5,570
97	6,365	6,908	11,619	1,736	8,798	5,716
98	6,528	7,084	11,911	1,781	9,020	5,860
99+	6,689	7,261	12,210	1,826	9,245	6,004

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
Male rates

Rates effective 8/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,179	4,539	7,629	1,139	5,773	3,545
65	2,788	3,024	5,083	759	3,850	2,364
66	2,788	3,024	5,083	759	3,850	2,364
67	2,788	3,024	5,083	759	3,850	2,364
68	2,818	3,056	5,143	769	3,893	2,449
69	2,875	3,123	5,250	785	3,976	2,548
70	2,949	3,199	5,383	805	4,073	2,638
71	3,040	3,301	5,550	829	4,201	2,738
72	3,134	3,404	5,724	856	4,333	2,829
73	3,238	3,514	5,906	884	4,474	2,926
74	3,348	3,633	6,111	914	4,623	3,020
75	3,469	3,765	6,333	948	4,793	3,123
76	3,591	3,898	6,554	979	4,960	3,223
77	3,719	4,036	6,781	1,015	5,141	3,329
78	3,844	4,173	7,016	1,048	5,311	3,443
79	3,971	4,305	7,244	1,084	5,485	3,556
80	4,094	4,445	7,473	1,119	5,658	3,675
81	4,223	4,585	7,706	1,151	5,835	3,791
82	4,354	4,726	7,949	1,189	6,019	3,911
83	4,486	4,874	8,191	1,225	6,205	4,030
84	4,628	5,021	8,445	1,263	6,391	4,151
85	4,781	5,193	8,725	1,305	6,605	4,293
86	4,916	5,338	8,973	1,343	6,794	4,413
87	5,056	5,490	9,229	1,381	6,985	4,539
88	5,198	5,643	9,489	1,419	7,185	4,666
89	5,341	5,798	9,751	1,459	7,381	4,794
90	5,491	5,959	10,019	1,499	7,586	4,926
91	5,641	6,121	10,293	1,539	7,794	5,060
92	5,793	6,288	10,574	1,580	8,004	5,200
93	5,946	6,451	10,849	1,621	8,214	5,338
94	6,101	6,621	11,143	1,665	8,435	5,480
95	6,264	6,798	11,430	1,709	8,654	5,619
96	6,423	6,974	11,725	1,754	8,879	5,768
97	6,589	7,150	12,023	1,798	9,104	5,918
98	6,755	7,333	12,331	1,843	9,336	6,064
99+	6,925	7,515	12,635	1,890	9,563	6,214

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,646	5,043	8,474	1,266	6,419	3,938
65	3,099	3,363	5,650	844	4,275	2,625
66	3,099	3,363	5,650	844	4,275	2,625
67	3,099	3,363	5,650	844	4,275	2,625
68	3,129	3,395	5,714	855	4,325	2,724
69	3,195	3,469	5,833	874	4,418	2,829
70	3,279	3,555	5,981	894	4,525	2,931
71	3,379	3,669	6,164	921	4,670	3,039
72	3,483	3,781	6,360	953	4,814	3,144
73	3,598	3,906	6,568	981	4,973	3,251
74	3,719	4,038	6,791	1,015	5,141	3,358
75	3,851	4,184	7,038	1,054	5,329	3,469
76	3,991	4,333	7,283	1,089	5,511	3,580
77	4,130	4,481	7,538	1,129	5,710	3,698
78	4,269	4,635	7,795	1,165	5,901	3,824
79	4,409	4,786	8,045	1,205	6,094	3,954
80	4,548	4,939	8,304	1,240	6,288	4,085
81	4,693	5,093	8,564	1,280	6,485	4,213
82	4,838	5,253	8,830	1,320	6,686	4,345
83	4,985	5,414	9,104	1,360	6,893	4,480
84	5,139	5,578	9,385	1,403	7,101	4,616
85	5,311	5,769	9,693	1,450	7,338	4,769
86	5,464	5,931	9,974	1,491	7,550	4,905
87	5,618	6,099	10,254	1,534	7,761	5,041
88	5,774	6,268	10,545	1,578	7,986	5,185
89	5,938	6,443	10,838	1,620	8,205	5,329
90	6,100	6,619	11,135	1,664	8,426	5,476
91	6,266	6,800	11,438	1,710	8,656	5,625
92	6,435	6,984	11,750	1,755	8,894	5,776
93	6,605	7,168	12,056	1,801	9,130	5,931
94	6,781	7,360	12,375	1,851	9,368	6,086
95	6,959	7,554	12,700	1,899	9,614	6,245
96	7,140	7,750	13,030	1,950	9,863	6,410
97	7,323	7,946	13,360	1,996	10,116	6,573
98	7,505	8,148	13,701	2,048	10,369	6,739
99+	7,693	8,350	14,039	2,100	10,630	6,905

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

IIn 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 be covered by an Aetna Company Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (b) someone with whom you are in a civil union partnership; and (c) 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 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 all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

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

THE FOLLOWING CHARTS DESCRIBE PLANS A, B, F, HIGH DEDUCTIBLE F, 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

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 $2,950 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,950. 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 $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 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.

****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,950 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,950. 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 $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	$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

HIGH DEDUCTIBLE PLAN F

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	$283 (Part B Deductible)	$0
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 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

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