Outline of coverage

Medicare Supplement Insurance

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

INDIANA

Underwritten by

Aetna Health and Life Insurance Company

AetnaSeniorProducts.com

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Rates effective: 08/2023 B

AETNA HEALTH AND LIFE 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. 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 2024[2]					**$7,060[2]**	**$3,530[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,800** 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 ZIP Codes: 463-464

Female Rates

Rates effective 8/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	9,938	---	---	---	---	---
65	1,808	1,912	2,814	679	1,913	1,842
66	1,808	1,912	2,814	679	1,913	1,842
67	1,808	1,912	2,814	679	1,913	1,842
68	1,826	1,930	2,845	686	1,934	1,909
69	1,869	1,975	2,909	702	1,977	1,987
70	1,919	2,027	2,988	720	2,028	2,062
71	1,975	2,087	3,076	742	2,091	2,134
72	2,039	2,154	3,174	766	2,155	2,207
73	2,104	2,224	3,276	791	2,226	2,282
74	2,178	2,303	3,390	819	2,304	2,361
75	2,254	2,384	3,509	847	2,385	2,436
76	2,333	2,467	3,631	877	2,468	2,514
77	2,416	2,553	3,761	907	2,554	2,598
78	2,497	2,638	3,888	938	2,640	2,683
79	2,575	2,723	4,008	967	2,725	2,770
80	2,658	2,807	4,134	999	2,811	2,864
81	2,740	2,895	4,266	1,029	2,898	2,953
82	2,822	2,980	4,393	1,060	2,985	3,040
83	2,909	3,074	4,527	1,093	3,076	3,134
84	2,995	3,163	4,660	1,125	3,166	3,227
85	3,103	3,277	4,830	1,166	3,282	3,343
86	3,191	3,371	4,968	1,199	3,373	3,441
87	3,282	3,466	5,110	1,233	3,472	3,536
88	3,372	3,566	5,252	1,268	3,569	3,634
89	3,467	3,663	5,396	1,304	3,669	3,736
90	3,562	3,764	5,546	1,339	3,767	3,838
91	3,659	3,867	5,698	1,375	3,870	3,945
92	3,757	3,971	5,849	1,413	3,975	4,051
93	3,858	4,076	6,006	1,450	4,080	4,156
94	3,961	4,184	6,165	1,488	4,189	4,268
95	4,063	4,293	6,327	1,528	4,298	4,380
96	4,169	4,407	6,490	1,566	4,410	4,492
97	4,276	4,518	6,656	1,605	4,522	4,608
98	4,384	4,631	6,825	1,646	4,635	4,725
99+	4,494	4,748	6,995	1,688	4,751	4,842

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	11,044	---	---	---	---	---
65	2,008	2,124	3,127	754	2,125	2,049
66	2,008	2,124	3,127	754	2,125	2,049
67	2,008	2,124	3,127	754	2,125	2,049
68	2,031	2,146	3,160	762	2,147	2,119
69	2,079	2,194	3,233	780	2,196	2,207
70	2,132	2,253	3,318	800	2,254	2,291
71	2,194	2,319	3,419	825	2,322	2,371
72	2,265	2,393	3,524	851	2,394	2,452
73	2,340	2,471	3,640	878	2,474	2,535
74	2,420	2,557	3,767	909	2,559	2,623
75	2,506	2,647	3,900	942	2,649	2,709
76	2,593	2,740	4,036	974	2,741	2,792
77	2,683	2,836	4,178	1,008	2,839	2,885
78	2,776	2,931	4,319	1,043	2,936	2,981
79	2,863	3,025	4,453	1,074	3,029	3,077
80	2,952	3,120	4,595	1,109	3,123	3,183
81	3,046	3,217	4,740	1,144	3,219	3,282
82	3,137	3,312	4,880	1,177	3,316	3,378
83	3,233	3,415	5,031	1,215	3,419	3,482
84	3,328	3,516	5,178	1,250	3,518	3,584
85	3,445	3,641	5,365	1,295	3,647	3,714
86	3,548	3,746	5,522	1,332	3,751	3,820
87	3,647	3,850	5,677	1,370	3,857	3,929
88	3,750	3,961	5,836	1,409	3,965	4,040
89	3,854	4,072	5,997	1,449	4,075	4,150
90	3,960	4,183	6,162	1,488	4,185	4,263
91	4,068	4,297	6,330	1,528	4,301	4,384
92	4,176	4,413	6,499	1,571	4,415	4,500
93	4,286	4,529	6,675	1,611	4,534	4,620
94	4,399	4,650	6,851	1,653	4,654	4,743
95	4,516	4,768	7,030	1,697	4,777	4,866
96	4,632	4,894	7,211	1,741	4,900	4,990
97	4,750	5,019	7,394	1,784	5,024	5,118
98	4,871	5,146	7,583	1,829	5,150	5,250
99+	4,991	5,277	7,773	1,877	5,281	5,380

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

To calculate a 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 and Life Insurance Company

Annual Premiums

For Use in ZIP Codes: 463-464

Male Rates

Rates effective 8/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	11,429	---	---	---	---	---
65	2,080	2,199	3,236	781	2,201	2,119
66	2,080	2,199	3,236	781	2,201	2,119
67	2,080	2,199	3,236	781	2,201	2,119
68	2,102	2,220	3,271	790	2,224	2,192
69	2,151	2,271	3,347	807	2,272	2,285
70	2,206	2,332	3,436	828	2,333	2,371
71	2,271	2,400	3,539	855	2,404	2,455
72	2,344	2,477	3,649	880	2,478	2,539
73	2,420	2,555	3,765	908	2,560	2,624
74	2,506	2,647	3,900	942	2,649	2,713
75	2,593	2,740	4,036	974	2,741	2,804
76	2,683	2,835	4,176	1,008	2,839	2,891
77	2,778	2,937	4,322	1,044	2,938	2,988
78	2,870	3,033	4,471	1,079	3,037	3,087
79	2,964	3,130	4,610	1,112	3,133	3,185
80	3,057	3,229	4,757	1,148	3,232	3,292
81	3,152	3,329	4,907	1,184	3,334	3,398
82	3,245	3,427	5,053	1,218	3,434	3,496
83	3,347	3,535	5,208	1,256	3,539	3,605
84	3,444	3,639	5,360	1,293	3,641	3,710
85	3,568	3,769	5,553	1,340	3,776	3,845
86	3,670	3,877	5,713	1,378	3,883	3,956
87	3,776	3,987	5,875	1,418	3,993	4,068
88	3,880	4,099	6,040	1,458	4,104	4,182
89	3,988	4,212	6,207	1,499	4,218	4,297
90	4,098	4,330	6,379	1,539	4,333	4,414
91	4,208	4,447	6,552	1,581	4,451	4,537
92	4,321	4,568	6,728	1,624	4,572	4,656
93	4,437	4,689	6,908	1,667	4,695	4,780
94	4,554	4,813	7,091	1,712	4,817	4,909
95	4,674	4,936	7,277	1,756	4,944	5,038
96	4,793	5,067	7,462	1,801	5,072	5,165
97	4,917	5,194	7,654	1,847	5,201	5,298
98	5,041	5,326	7,847	1,893	5,333	5,433
99+	5,169	5,459	8,042	1,942	5,466	5,568

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	12,695	---	---	---	---	---
65	2,310	2,442	3,596	867	2,444	2,357
66	2,310	2,442	3,596	867	2,444	2,357
67	2,310	2,442	3,596	867	2,444	2,357
68	2,336	2,468	3,633	877	2,470	2,436
69	2,390	2,525	3,718	897	2,526	2,539
70	2,452	2,590	3,815	921	2,593	2,636
71	2,525	2,667	3,932	949	2,673	2,727
72	2,604	2,754	4,054	979	2,755	2,820
73	2,688	2,842	4,185	1,009	2,845	2,916
74	2,784	2,941	4,333	1,046	2,942	3,016
75	2,881	3,046	4,485	1,083	3,047	3,111
76	2,980	3,152	4,642	1,121	3,155	3,213
77	3,087	3,262	4,805	1,160	3,263	3,318
78	3,191	3,371	4,968	1,199	3,373	3,429
79	3,291	3,479	5,121	1,235	3,481	3,540
80	3,395	3,587	5,284	1,275	3,593	3,661
81	3,502	3,700	5,451	1,315	3,704	3,776
82	3,608	3,809	5,611	1,355	3,813	3,886
83	3,718	3,925	5,786	1,397	3,932	4,005
84	3,827	4,043	5,954	1,438	4,047	4,123
85	3,964	4,186	6,171	1,489	4,192	4,271
86	4,077	4,308	6,349	1,531	4,314	4,394
87	4,192	4,428	6,528	1,575	4,436	4,519
88	4,312	4,554	6,712	1,621	4,560	4,646
89	4,429	4,682	6,896	1,666	4,686	4,776
90	4,552	4,811	7,089	1,712	4,814	4,903
91	4,676	4,942	7,279	1,756	4,946	5,041
92	4,804	5,075	7,475	1,806	5,080	5,175
93	4,931	5,210	7,676	1,853	5,213	5,313
94	5,059	5,346	7,878	1,901	5,355	5,453
95	5,192	5,484	8,083	1,951	5,493	5,596
96	5,327	5,627	8,293	2,002	5,635	5,737
97	5,465	5,771	8,503	2,052	5,778	5,886
98	5,602	5,916	8,722	2,104	5,923	6,037
99+	5,742	6,066	8,938	2,158	6,073	6,187

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

To calculate a 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 and Life Insurance Company

Annual Premiums

For Use in: Rest of State

Female Rates

Rates effective 8/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	8,567	-	-	-	-	-
65	1,559	1,648	2,426	585	1,649	1,588
66	1,559	1,648	2,426	585	1,649	1,588
67	1,559	1,648	2,426	585	1,649	1,588
68	1,574	1,664	2,453	591	1,667	1,646
69	1,611	1,703	2,508	605	1,704	1,713
70	1,654	1,747	2,576	621	1,748	1,778
71	1,703	1,799	2,652	640	1,803	1,840
72	1,758	1,857	2,736	660	1,858	1,903
73	1,814	1,917	2,824	682	1,919	1,967
74	1,878	1,985	2,922	706	1,986	2,035
75	1,943	2,055	3,025	730	2,056	2,100
76	2,011	2,127	3,130	756	2,128	2,167
77	2,083	2,201	3,242	782	2,202	2,240
78	2,153	2,274	3,352	809	2,276	2,313
79	2,220	2,347	3,455	834	2,349	2,388
80	2,291	2,420	3,564	861	2,423	2,469
81	2,362	2,496	3,678	887	2,498	2,546
82	2,433	2,569	3,787	914	2,573	2,621
83	2,508	2,650	3,903	942	2,652	2,702
84	2,582	2,727	4,017	970	2,729	2,782
85	2,675	2,825	4,164	1,005	2,829	2,882
86	2,751	2,906	4,283	1,034	2,908	2,966
87	2,829	2,988	4,405	1,063	2,993	3,048
88	2,907	3,074	4,528	1,093	3,077	3,133
89	2,989	3,158	4,652	1,124	3,163	3,221
90	3,071	3,245	4,781	1,154	3,247	3,309
91	3,154	3,334	4,912	1,185	3,336	3,401
92	3,239	3,423	5,042	1,218	3,427	3,492
93	3,326	3,514	5,178	1,250	3,517	3,583
94	3,415	3,607	5,315	1,283	3,611	3,679
95	3,503	3,701	5,454	1,317	3,705	3,776
96	3,594	3,799	5,595	1,350	3,802	3,872
97	3,686	3,895	5,738	1,384	3,898	3,972
98	3,779	3,992	5,884	1,419	3,996	4,073
99+	3,874	4,093	6,030	1,455	4,096	4,174

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	9,521	-	-	-	-	-
65	1,731	1,831	2,696	650	1,832	1,766
66	1,731	1,831	2,696	650	1,832	1,766
67	1,731	1,831	2,696	650	1,832	1,766
68	1,751	1,850	2,724	657	1,851	1,827
69	1,792	1,891	2,787	672	1,893	1,903
70	1,838	1,942	2,860	690	1,943	1,975
71	1,891	1,999	2,947	711	2,002	2,044
72	1,953	2,063	3,038	734	2,064	2,114
73	2,017	2,130	3,138	757	2,133	2,185
74	2,086	2,204	3,247	784	2,206	2,261
75	2,160	2,282	3,362	812	2,284	2,335
76	2,235	2,362	3,479	840	2,363	2,407
77	2,313	2,445	3,602	869	2,447	2,487
78	2,393	2,527	3,723	899	2,531	2,570
79	2,468	2,608	3,839	926	2,611	2,653
80	2,545	2,690	3,961	956	2,692	2,744
81	2,626	2,773	4,086	986	2,775	2,829
82	2,704	2,855	4,207	1,015	2,859	2,912
83	2,787	2,944	4,337	1,047	2,947	3,002
84	2,869	3,031	4,464	1,078	3,033	3,090
85	2,970	3,139	4,625	1,116	3,144	3,202
86	3,059	3,229	4,760	1,148	3,234	3,293
87	3,144	3,319	4,894	1,181	3,325	3,387
88	3,233	3,415	5,031	1,215	3,418	3,483
89	3,322	3,510	5,170	1,249	3,513	3,578
90	3,414	3,606	5,312	1,283	3,608	3,675
91	3,507	3,704	5,457	1,317	3,708	3,779
92	3,600	3,804	5,603	1,354	3,806	3,879
93	3,695	3,904	5,754	1,389	3,909	3,983
94	3,792	4,009	5,906	1,425	4,012	4,089
95	3,893	4,110	6,060	1,463	4,118	4,195
96	3,993	4,219	6,216	1,501	4,224	4,302
97	4,095	4,327	6,374	1,538	4,331	4,412
98	4,199	4,436	6,537	1,577	4,440	4,526
99+	4,303	4,549	6,701	1,618	4,553	4,638

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

To calculate a 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 and Life Insurance Company

Annual Premiums

For Use in: Rest of State

Male Rates

Rates effective 8/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	9,853	-	-	-	-	-
65	1,793	1,896	2,790	673	1,897	1,827
66	1,793	1,896	2,790	673	1,897	1,827
67	1,793	1,896	2,790	673	1,897	1,827
68	1,812	1,914	2,820	681	1,917	1,890
69	1,854	1,958	2,885	696	1,959	1,970
70	1,902	2,010	2,962	714	2,011	2,044
71	1,958	2,069	3,051	737	2,072	2,116
72	2,021	2,135	3,146	759	2,136	2,189
73	2,086	2,203	3,246	783	2,207	2,262
74	2,160	2,282	3,362	812	2,284	2,339
75	2,235	2,362	3,479	840	2,363	2,417
76	2,313	2,444	3,600	869	2,447	2,492
77	2,395	2,532	3,726	900	2,533	2,576
78	2,474	2,615	3,854	930	2,618	2,661
79	2,555	2,698	3,974	959	2,701	2,746
80	2,635	2,784	4,101	990	2,786	2,838
81	2,717	2,870	4,230	1,021	2,874	2,929
82	2,797	2,954	4,356	1,050	2,960	3,014
83	2,885	3,047	4,490	1,083	3,051	3,108
84	2,969	3,137	4,621	1,115	3,139	3,198
85	3,076	3,249	4,787	1,155	3,255	3,315
86	3,164	3,342	4,925	1,188	3,347	3,410
87	3,255	3,437	5,065	1,222	3,442	3,507
88	3,345	3,534	5,207	1,257	3,538	3,605
89	3,438	3,631	5,351	1,292	3,636	3,704
90	3,533	3,733	5,499	1,327	3,735	3,805
91	3,628	3,834	5,648	1,363	3,837	3,911
92	3,725	3,938	5,800	1,400	3,941	4,014
93	3,825	4,042	5,955	1,437	4,047	4,121
94	3,926	4,149	6,113	1,476	4,153	4,232
95	4,029	4,255	6,273	1,514	4,262	4,343
96	4,132	4,368	6,433	1,553	4,372	4,453
97	4,239	4,478	6,598	1,592	4,484	4,567
98	4,346	4,591	6,765	1,632	4,597	4,684
99+	4,456	4,706	6,933	1,674	4,712	4,800

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	10,944	-	-	-	-	-
65	1,991	2,105	3,100	747	2,107	2,032
66	1,991	2,105	3,100	747	2,107	2,032
67	1,991	2,105	3,100	747	2,107	2,032
68	2,014	2,128	3,132	756	2,129	2,100
69	2,060	2,177	3,205	773	2,178	2,189
70	2,114	2,233	3,289	794	2,235	2,272
71	2,177	2,299	3,390	818	2,304	2,351
72	2,245	2,374	3,495	844	2,375	2,431
73	2,317	2,450	3,608	870	2,453	2,514
74	2,400	2,535	3,735	902	2,536	2,600
75	2,484	2,626	3,866	934	2,627	2,682
76	2,569	2,717	4,002	966	2,720	2,770
77	2,661	2,812	4,142	1,000	2,813	2,860
78	2,751	2,906	4,283	1,034	2,908	2,956
79	2,837	2,999	4,415	1,065	3,001	3,052
80	2,927	3,092	4,555	1,099	3,097	3,156
81	3,019	3,190	4,699	1,134	3,193	3,255
82	3,110	3,284	4,837	1,168	3,287	3,350
83	3,205	3,384	4,988	1,204	3,390	3,453
84	3,299	3,485	5,133	1,240	3,489	3,554
85	3,417	3,609	5,320	1,284	3,614	3,682
86	3,515	3,714	5,473	1,320	3,719	3,788
87	3,614	3,817	5,628	1,358	3,824	3,896
88	3,717	3,926	5,786	1,397	3,931	4,005
89	3,818	4,036	5,945	1,436	4,040	4,117
90	3,924	4,147	6,111	1,476	4,150	4,227
91	4,031	4,260	6,275	1,514	4,264	4,346
92	4,141	4,375	6,444	1,557	4,379	4,461
93	4,251	4,491	6,617	1,597	4,494	4,580
94	4,361	4,609	6,791	1,639	4,616	4,701
95	4,476	4,728	6,968	1,682	4,735	4,824
96	4,592	4,851	7,149	1,726	4,858	4,946
97	4,711	4,975	7,330	1,769	4,981	5,074
98	4,829	5,100	7,519	1,814	5,106	5,204
99+	4,950	5,229	7,705	1,860	5,235	5,334

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

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

POLICY REPLACEMENT

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

NOTICE

The policy may not cover all of your medical costs. Neither Aetna Health and Life Insurance Company nor its agents are connected with Medicare.

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER CALENDAR YEAR

*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 $1,632	$0	$1,632 (Part A Deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 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.

***Deductible amounts announced annually by CMS

PLAN A

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

*Once you have been billed $240 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

***Deductible amounts announced annually by CMS

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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 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.

***Deductible amounts announced annually by CMS

PLAN B

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

*Once you have been billed $240 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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.

***Deductible amounts announced annually by CMS

PLAN F

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

*Once you have been billed $240 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 $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

***Deductible amounts announced annually by CMS

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

***Deductible amounts announced annually by CMS

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 $2,800 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,800. 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 $2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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.

***Deductible amounts announced annually by CMS

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $240 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 $2,800 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,800. 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 $2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,800 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 $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

***Deductible amounts announced annually by CMS

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,800 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

***Deductible amounts announced annually by CMS

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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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.

***Deductible amounts announced annually by CMS

PLAN G

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

*Once you have been billed $240 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

***Deductible amounts announced annually by CMS

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

***Deductible amounts announced annually by CMS

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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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.

***Deductible amounts announced annually by CMS

PLAN N

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

*Once you have been billed $240 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

***Deductible amounts announced annually by CMS

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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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

***Deductible amounts announced annually by CMS