Outline of coverage

Medicare Supplement Insurance

Benefit plans: A, B, F, G, High Deductible G, N

Kansas

Underwritten by

Aetna Health Insurance Company

aetnaseniorproducts.com

AHCMS04870KS

Rates effective: 03/2022 A

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

This chart shows the benefits included in each of the standard Medicare supplement plans. 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.

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 2022[2]					**$6,620[2]**	**$3,310[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,490 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 : Rest of State

Female Rates

Rates Effective 3/1/2022

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,337	1,548	1,684	1,499	544	1,012
65	1,337	1,548	1,684	1,499	544	1,012
66	1,337	1,548	1,684	1,499	544	1,012
67	1,337	1,548	1,684	1,499	544	1,012
68	1,352	1,564	1,701	1,515	549	1,049
69	1,382	1,601	1,741	1,550	562	1,091
70	1,418	1,644	1,788	1,591	577	1,133
71	1,461	1,693	1,841	1,638	594	1,173
72	1,506	1,746	1,899	1,690	613	1,214
73	1,555	1,802	1,960	1,745	633	1,254
74	1,610	1,866	2,028	1,807	655	1,296
75	1,667	1,930	2,100	1,869	678	1,337
76	1,724	1,999	2,173	1,935	702	1,381
77	1,785	2,069	2,251	2,002	726	1,427
78	1,848	2,139	2,327	2,071	751	1,475
79	1,904	2,206	2,400	2,135	775	1,522
80	1,965	2,276	2,475	2,203	799	1,573
81	2,026	2,348	2,553	2,272	824	1,623
82	2,086	2,417	2,629	2,339	849	1,671
83	2,151	2,491	2,710	2,412	875	1,723
84	2,214	2,564	2,789	2,482	900	1,773
85	2,294	2,657	2,890	2,573	933	1,837
86	2,360	2,734	2,972	2,647	960	1,889
87	2,426	2,811	3,057	2,722	987	1,943
88	2,495	2,890	3,142	2,797	1,015	1,997
89	2,564	2,970	3,231	2,875	1,043	2,052
90	2,635	3,051	3,319	2,955	1,072	2,110
91	2,706	3,135	3,410	3,035	1,101	2,168
92	2,780	3,220	3,501	3,117	1,130	2,226
93	2,854	3,306	3,595	3,199	1,160	2,285
94	2,929	3,393	3,690	3,284	1,191	2,345
95	3,005	3,481	3,786	3,370	1,222	2,406
96	3,084	3,571	3,884	3,457	1,254	2,468
97	3,161	3,662	3,983	3,545	1,286	2,531
98	3,241	3,754	4,083	3,634	1,318	2,596
99+	3,322	3,849	4,185	3,726	1,351	2,660

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,486	1,720	1,872	1,665	604	1,124
65	1,486	1,720	1,872	1,665	604	1,124
66	1,486	1,720	1,872	1,665	604	1,124
67	1,486	1,720	1,872	1,665	604	1,124
68	1,502	1,739	1,891	1,683	610	1,165
69	1,535	1,779	1,934	1,723	624	1,213
70	1,576	1,826	1,986	1,768	641	1,259
71	1,623	1,881	2,045	1,821	660	1,304
72	1,674	1,940	2,110	1,878	681	1,348
73	1,728	2,002	2,177	1,939	703	1,393
74	1,790	2,073	2,254	2,008	728	1,440
75	1,852	2,145	2,334	2,077	753	1,486
76	1,916	2,221	2,414	2,149	780	1,535
77	1,985	2,298	2,500	2,226	807	1,585
78	2,051	2,377	2,585	2,301	834	1,638
79	2,117	2,451	2,666	2,373	861	1,691
80	2,182	2,529	2,750	2,448	888	1,748
81	2,251	2,608	2,835	2,524	916	1,803
82	2,318	2,685	2,921	2,600	943	1,856
83	2,389	2,768	3,011	2,681	972	1,914
84	2,460	2,849	3,099	2,757	1,000	1,970
85	2,550	2,953	3,211	2,859	1,037	2,041
86	2,623	3,037	3,304	2,941	1,067	2,099
87	2,696	3,123	3,396	3,023	1,097	2,159
88	2,771	3,211	3,491	3,107	1,128	2,220
89	2,849	3,299	3,589	3,195	1,159	2,281
90	2,928	3,390	3,689	3,282	1,191	2,344
91	3,006	3,484	3,789	3,372	1,223	2,408
92	3,088	3,577	3,890	3,464	1,256	2,472
93	3,170	3,673	3,994	3,555	1,289	2,539
94	3,254	3,769	4,099	3,649	1,323	2,606
95	3,340	3,868	4,205	3,744	1,358	2,673
96	3,426	3,968	4,314	3,840	1,393	2,743
97	3,512	4,070	4,425	3,939	1,429	2,812
98	3,601	4,170	4,538	4,038	1,464	2,885
99+	3,692	4,276	4,649	4,140	1,501	2,956

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

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 Period, use Preferred rates.

Aetna Health Insurance Company

Annual Premiums
For Use in : Rest of State
Male Rates

Rates Effective 3/1/2022

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,537	1,780	1,938	1,724	626	1,164
65	1,537	1,780	1,938	1,724	626	1,164
66	1,537	1,780	1,938	1,724	626	1,164
67	1,537	1,780	1,938	1,724	626	1,164
68	1,554	1,799	1,958	1,743	631	1,205
69	1,589	1,841	2,002	1,782	646	1,255
70	1,632	1,889	2,056	1,831	664	1,303
71	1,680	1,947	2,117	1,885	683	1,349
72	1,733	2,007	2,182	1,943	705	1,396
73	1,789	2,073	2,253	2,007	728	1,441
74	1,852	2,146	2,333	2,077	753	1,490
75	1,916	2,220	2,415	2,149	780	1,538
76	1,984	2,299	2,499	2,226	807	1,588
77	2,055	2,379	2,588	2,304	835	1,641
78	2,123	2,460	2,676	2,381	864	1,696
79	2,191	2,536	2,760	2,456	891	1,750
80	2,260	2,617	2,846	2,534	919	1,808
81	2,329	2,699	2,934	2,613	948	1,867
82	2,399	2,780	3,023	2,691	976	1,921
83	2,473	2,865	3,116	2,773	1,006	1,982
84	2,546	2,948	3,208	2,854	1,035	2,039
85	2,638	3,056	3,323	2,959	1,073	2,113
86	2,714	3,144	3,419	3,043	1,104	2,173
87	2,790	3,233	3,516	3,130	1,135	2,235
88	2,869	3,323	3,614	3,217	1,167	2,297
89	2,948	3,415	3,715	3,307	1,199	2,360
90	3,030	3,509	3,817	3,398	1,233	2,426
91	3,113	3,605	3,922	3,489	1,266	2,492
92	3,196	3,703	4,026	3,585	1,300	2,560
93	3,282	3,801	4,134	3,678	1,334	2,628
94	3,368	3,901	4,242	3,777	1,370	2,698
95	3,456	4,004	4,352	3,875	1,405	2,766
96	3,546	4,106	4,466	3,977	1,442	2,839
97	3,635	4,212	4,580	4,077	1,479	2,911
98	3,727	4,316	4,696	4,180	1,516	2,986
99+	3,820	4,425	4,812	4,284	1,554	3,059

Modal Factors: Semi-Annual: 0.5200

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,708	1,977	2,153	1,915	695	1,293
65	1,708	1,977	2,153	1,915	695	1,293
66	1,708	1,977	2,153	1,915	695	1,293
67	1,708	1,977	2,153	1,915	695	1,293
68	1,727	2,000	2,176	1,935	702	1,340
69	1,766	2,046	2,225	1,982	718	1,394
70	1,813	2,100	2,285	2,033	737	1,448
71	1,867	2,164	2,352	2,094	759	1,499
72	1,925	2,231	2,426	2,160	783	1,550
73	1,987	2,302	2,504	2,229	808	1,601
74	2,058	2,384	2,593	2,308	837	1,656
75	2,130	2,467	2,684	2,389	866	1,709
76	2,204	2,555	2,777	2,472	897	1,766
77	2,282	2,643	2,875	2,560	928	1,823
78	2,359	2,734	2,974	2,647	959	1,884
79	2,434	2,819	3,066	2,728	990	1,944
80	2,510	2,908	3,162	2,816	1,021	2,010
81	2,589	3,000	3,260	2,903	1,053	2,074
82	2,665	3,088	3,358	2,989	1,084	2,136
83	2,749	3,183	3,463	3,082	1,118	2,201
84	2,830	3,277	3,563	3,172	1,150	2,265
85	2,932	3,395	3,693	3,289	1,193	2,348
86	3,016	3,492	3,799	3,381	1,227	2,414
87	3,101	3,592	3,907	3,477	1,262	2,484
88	3,187	3,693	4,016	3,574	1,297	2,552
89	3,277	3,794	4,128	3,674	1,333	2,623
90	3,367	3,899	4,241	3,775	1,370	2,697
91	3,457	4,006	4,357	3,878	1,406	2,769
92	3,550	4,115	4,473	3,982	1,444	2,844
93	3,646	4,224	4,594	4,088	1,482	2,919
94	3,742	4,335	4,714	4,197	1,521	2,998
95	3,841	4,448	4,836	4,306	1,562	3,074
96	3,940	4,563	4,962	4,417	1,602	3,155
97	4,037	4,680	5,089	4,531	1,643	3,234
98	4,141	4,796	5,218	4,643	1,684	3,317
99+	4,244	4,917	5,348	4,760	1,726	3,400

Quarterly: 0.2650 Monthly: 0.0833

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 Period, use Preferred rates.

Aetna Health Insurance Company

Annual Premiums

For Use in ZIP Codes: 661-662, 672

Female Rates

Rates Effective 3/1/2022

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,444	1,672	1,819	1,619	588	1,093
65	1,444	1,672	1,819	1,619	588	1,093
66	1,444	1,672	1,819	1,619	588	1,093
67	1,444	1,672	1,819	1,619	588	1,093
68	1,460	1,689	1,837	1,636	593	1,133
69	1,493	1,729	1,880	1,674	607	1,178
70	1,531	1,776	1,931	1,718	623	1,224
71	1,578	1,828	1,988	1,769	642	1,267
72	1,626	1,886	2,051	1,825	662	1,311
73	1,679	1,946	2,117	1,885	684	1,354
74	1,739	2,015	2,190	1,952	707	1,400
75	1,800	2,084	2,268	2,019	732	1,444
76	1,862	2,159	2,347	2,090	758	1,491
77	1,928	2,235	2,431	2,162	784	1,541
78	1,996	2,310	2,513	2,237	811	1,593
79	2,056	2,382	2,592	2,306	837	1,644
80	2,122	2,458	2,673	2,379	863	1,699
81	2,188	2,536	2,757	2,454	890	1,753
82	2,253	2,610	2,839	2,526	917	1,805
83	2,323	2,690	2,927	2,605	945	1,861
84	2,391	2,769	3,012	2,681	972	1,915
85	2,478	2,870	3,121	2,779	1,008	1,984
86	2,549	2,953	3,210	2,859	1,037	2,040
87	2,620	3,036	3,302	2,940	1,066	2,098
88	2,695	3,121	3,393	3,021	1,096	2,157
89	2,769	3,208	3,489	3,105	1,126	2,216
90	2,846	3,295	3,585	3,191	1,158	2,279
91	2,922	3,386	3,683	3,278	1,189	2,341
92	3,002	3,478	3,781	3,366	1,220	2,404
93	3,082	3,570	3,883	3,455	1,253	2,468
94	3,163	3,664	3,985	3,547	1,286	2,533
95	3,245	3,759	4,089	3,640	1,320	2,598
96	3,331	3,857	4,195	3,734	1,354	2,665
97	3,414	3,955	4,302	3,829	1,389	2,733
98	3,500	4,054	4,410	3,925	1,423	2,804
99+	3,588	4,157	4,520	4,024	1,459	2,873

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,605	1,858	2,022	1,798	652	1,214
65	1,605	1,858	2,022	1,798	652	1,214
66	1,605	1,858	2,022	1,798	652	1,214
67	1,605	1,858	2,022	1,798	652	1,214
68	1,622	1,878	2,042	1,818	659	1,258
69	1,658	1,921	2,089	1,861	674	1,310
70	1,702	1,972	2,145	1,909	692	1,360
71	1,753	2,031	2,209	1,967	713	1,408
72	1,808	2,095	2,279	2,028	735	1,456
73	1,866	2,162	2,351	2,094	759	1,504
74	1,933	2,239	2,434	2,169	786	1,555
75	2,000	2,317	2,521	2,243	813	1,605
76	2,069	2,399	2,607	2,321	842	1,658
77	2,144	2,482	2,700	2,404	872	1,712
78	2,215	2,567	2,792	2,485	901	1,769
79	2,286	2,647	2,879	2,563	930	1,826
80	2,357	2,731	2,970	2,644	959	1,888
81	2,431	2,817	3,062	2,726	989	1,947
82	2,503	2,900	3,155	2,808	1,018	2,004
83	2,580	2,989	3,252	2,895	1,050	2,067
84	2,657	3,077	3,347	2,978	1,080	2,128
85	2,754	3,189	3,468	3,088	1,120	2,204
86	2,833	3,280	3,568	3,176	1,152	2,267
87	2,912	3,373	3,668	3,265	1,185	2,332
88	2,993	3,468	3,770	3,356	1,218	2,398
89	3,077	3,563	3,876	3,451	1,252	2,463
90	3,162	3,661	3,984	3,545	1,286	2,532
91	3,246	3,763	4,092	3,642	1,321	2,601
92	3,335	3,863	4,201	3,741	1,356	2,670
93	3,424	3,967	4,314	3,839	1,392	2,742
94	3,514	4,071	4,427	3,941	1,429	2,814
95	3,607	4,177	4,541	4,044	1,467	2,887
96	3,700	4,285	4,659	4,147	1,504	2,962
97	3,793	4,396	4,779	4,254	1,543	3,037
98	3,889	4,504	4,901	4,361	1,581	3,116
99+	3,987	4,618	5,021	4,471	1,621	3,192

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

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 Period, use Preferred rates.

Aetna Health Insurance Company

Annual Premiums

For Use in ZIP Codes: 661-662, 672

Male Rates

Rates Effective 3/1/2022

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,660	1,922	2,093	1,862	676	1,257
65	1,660	1,922	2,093	1,862	676	1,257
66	1,660	1,922	2,093	1,862	676	1,257
67	1,660	1,922	2,093	1,862	676	1,257
68	1,678	1,943	2,115	1,882	681	1,301
69	1,716	1,988	2,162	1,925	698	1,355
70	1,763	2,040	2,220	1,977	717	1,407
71	1,814	2,103	2,286	2,036	738	1,457
72	1,872	2,168	2,357	2,098	761	1,508
73	1,932	2,239	2,433	2,168	786	1,556
74	2,000	2,318	2,520	2,243	813	1,609
75	2,069	2,398	2,608	2,321	842	1,661
76	2,143	2,483	2,699	2,404	872	1,715
77	2,219	2,569	2,795	2,488	902	1,772
78	2,293	2,657	2,890	2,571	933	1,832
79	2,366	2,739	2,981	2,652	962	1,890
80	2,441	2,826	3,074	2,737	993	1,953
81	2,515	2,915	3,169	2,822	1,024	2,016
82	2,591	3,002	3,265	2,906	1,054	2,075
83	2,671	3,094	3,365	2,995	1,086	2,141
84	2,750	3,184	3,465	3,082	1,118	2,202
85	2,849	3,300	3,589	3,196	1,159	2,282
86	2,931	3,396	3,693	3,286	1,192	2,347
87	3,013	3,492	3,797	3,380	1,226	2,414
88	3,099	3,589	3,903	3,474	1,260	2,481
89	3,184	3,688	4,012	3,572	1,295	2,549
90	3,272	3,790	4,122	3,670	1,332	2,620
91	3,362	3,893	4,236	3,768	1,367	2,691
92	3,452	3,999	4,348	3,872	1,404	2,765
93	3,545	4,105	4,465	3,972	1,441	2,838
94	3,637	4,213	4,581	4,079	1,480	2,914
95	3,732	4,324	4,700	4,185	1,517	2,987
96	3,830	4,434	4,823	4,295	1,557	3,066
97	3,926	4,549	4,946	4,403	1,597	3,144
98	4,025	4,661	5,072	4,514	1,637	3,225
99+	4,126	4,779	5,197	4,627	1,678	3,304

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,845	2,135	2,325	2,068	751	1,396
65	1,845	2,135	2,325	2,068	751	1,396
66	1,845	2,135	2,325	2,068	751	1,396
67	1,845	2,135	2,325	2,068	751	1,396
68	1,865	2,160	2,350	2,090	758	1,447
69	1,907	2,210	2,403	2,141	775	1,506
70	1,958	2,268	2,468	2,196	796	1,564
71	2,016	2,337	2,540	2,262	820	1,619
72	2,079	2,409	2,620	2,333	846	1,674
73	2,146	2,486	2,704	2,407	873	1,729
74	2,223	2,575	2,800	2,493	904	1,788
75	2,300	2,664	2,899	2,580	935	1,846
76	2,380	2,759	2,999	2,670	969	1,907
77	2,465	2,854	3,105	2,765	1,002	1,969
78	2,548	2,953	3,212	2,859	1,036	2,035
79	2,629	3,045	3,311	2,946	1,069	2,100
80	2,711	3,141	3,415	3,041	1,103	2,171
81	2,796	3,240	3,521	3,135	1,137	2,240
82	2,878	3,335	3,627	3,228	1,171	2,307
83	2,969	3,438	3,740	3,329	1,207	2,377
84	3,056	3,539	3,848	3,426	1,242	2,446
85	3,167	3,667	3,988	3,552	1,288	2,536
86	3,257	3,771	4,103	3,651	1,325	2,607
87	3,349	3,879	4,220	3,755	1,363	2,683
88	3,442	3,988	4,337	3,860	1,401	2,756
89	3,539	4,098	4,458	3,968	1,440	2,833
90	3,636	4,211	4,580	4,077	1,480	2,913
91	3,734	4,326	4,706	4,188	1,518	2,991
92	3,834	4,444	4,831	4,301	1,560	3,072
93	3,938	4,562	4,962	4,415	1,601	3,153
94	4,041	4,682	5,091	4,533	1,643	3,238
95	4,148	4,804	5,223	4,650	1,687	3,320
96	4,255	4,928	5,359	4,770	1,730	3,407
97	4,360	5,054	5,496	4,893	1,774	3,493
98	4,472	5,180	5,635	5,014	1,819	3,582
99+	4,584	5,310	5,776	5,141	1,864	3,672

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

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 Period, use Preferred rates.

PREMIUM INFORMATION

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

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

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

HOUSEHOLD DISCOUNT

In order to be eligible for the Household discount under an Aetna Health Insurance Company Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently have a Medicare supplement policy with an Aetna company. The Medicare eligible adult must be either (a) your spouse or someone with whom you are in a civil union partnership; and (b) someone with whom you have continuously resided for the past 12 months. The household discount will only be applicable if a policy for each applicant is issued. The discounted rates will be 7 percent lower than the individual rates and will apply as long as both policies remain in force.

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

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

YOU HAVE PURCHASED PLAN _____.

PREMIUM FOR THIS PLAN IS $_____.

PREMIUM WILL BE PAID _____.

AGENT'S NAME:_____

AGENT'S ADDRESS:_____

SIGNATURE/DATE:_____

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, 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 Insurance Company nor its agents are connected with Medicare.

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,556	$0	$1,556 (Part A Deductible)
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	$0	Up to $194.50 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 $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$0	$233 (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 $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	$0	Up to $194.50 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 B

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

* Once you have been billed $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$0	$233 (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 $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 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 $233 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 test, durable medical equipment			
First $233 of Medicare-Approved amounts*	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$233 (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 $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$0	$233 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

HIGH DEDUCTIBLE PLAN G

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

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

*****This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,490 deductible. Benefits from high deductible plan G will not begin until out-of-pocket expenses are $2,490. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,490 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
*While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 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.

HIGH DEDUCTIBLE PLAN G

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

*Once you have been billed $233 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

*****This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,490 deductible. Benefits from high deductible plan G will not begin until out-of-pocket expenses are $2,490. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,490 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,490 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $233 of Medicare-Approved amounts*	$0	$0	$233 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,490 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
*Medically necessary skilled care services and medical supplies	100%	$0	$0
*Durable medical equipment			
First $233 of Medicare Approved amounts	$0	$0	$233 (Unless Part B Deductible has been met)
*Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,490 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
*While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 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.
Part B Excess Charges (Above Medicare-Approved amounts)	$0	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare Approved amounts	$0	$0	$233 (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