Outline of coverage

Medicare Supplement Insurance

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

Kentucky

Underwritten by

Aetna Health and Life Insurance Company

AetnaSeniorProducts.com

AHLMS05546KY

Rates effective: 05/2024 A

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.
Every Company must make Plan "A and either Plan C or F available for those eligible for Medicare prior to January 1, 2020 and either Plan D or G available for those eligible for Medicare on or after January 1 2020."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

Note: A ✓ means 100% of the benefit is paid. Some plans may not be available.

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 Attained Age Premiums

For Use in ZIP Codes: 402, 410, 416-418

Female Rates

Rates effective 5/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,542	2,980	3,880	898	2,703	1,624
65	2,160	2,448	3,146	729	2,177	1,298
66	2,220	2,529	3,257	753	2,255	1,347
67	2,280	2,607	3,357	777	2,325	1,390
68	2,339	2,682	3,465	803	2,399	1,434
69	2,399	2,760	3,563	827	2,471	1,481
70	2,455	2,832	3,666	849	2,547	1,523
71	2,515	2,911	3,766	872	2,615	1,567
72	2,571	2,981	3,866	895	2,686	1,610
73	2,617	3,056	3,971	920	2,762	1,656
74	2,669	3,130	4,072	944	2,839	1,702
75	2,715	3,203	4,178	967	2,913	1,750
76	2,761	3,278	4,276	991	2,981	1,795
77	2,808	3,352	4,379	1,015	3,054	1,840
78	2,841	3,416	4,478	1,037	3,129	1,889
79	2,869	3,481	4,577	1,060	3,205	1,934
80	2,899	3,548	4,676	1,083	3,278	1,981
81	2,930	3,617	4,773	1,105	3,351	2,030
82	2,958	3,679	4,871	1,128	3,422	2,075
83	2,995	3,739	4,969	1,151	3,498	2,126
84	3,035	3,798	5,066	1,172	3,571	2,175
85	3,062	3,843	5,144	1,191	3,637	2,218
86	3,095	3,892	5,229	1,212	3,704	2,262
87	3,122	3,942	5,312	1,232	3,771	2,310
88	3,151	3,994	5,404	1,251	3,841	2,358
89	3,183	4,042	5,487	1,271	3,909	2,404
90	3,213	4,089	5,572	1,290	3,980	2,447
91	3,245	4,139	5,655	1,310	4,045	2,494
92	3,274	4,186	5,742	1,329	4,114	2,538
93	3,310	4,232	5,821	1,349	4,177	2,581
94	3,338	4,275	5,898	1,366	4,246	2,629
95	3,372	4,318	5,980	1,385	4,306	2,669
96	3,403	4,361	6,056	1,403	4,368	2,713
97	3,437	4,406	6,133	1,421	4,430	2,754
98	3,473	4,448	6,211	1,438	4,488	2,796
99+	3,502	4,491	6,287	1,456	4,549	2,836

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,824	3,311	4,311	998	3,003	1,804
65	2,399	2,720	3,498	810	2,421	1,444
66	2,469	2,807	3,618	837	2,504	1,494
67	2,535	2,895	3,734	865	2,583	1,544
68	2,599	2,979	3,847	891	2,668	1,594
69	2,668	3,064	3,962	919	2,746	1,643
70	2,730	3,149	4,072	944	2,827	1,691
71	2,797	3,232	4,184	969	2,906	1,741
72	2,858	3,314	4,295	996	2,987	1,786
73	2,912	3,397	4,411	1,022	3,067	1,840
74	2,966	3,479	4,528	1,050	3,153	1,893
75	3,016	3,562	4,638	1,074	3,233	1,944
76	3,073	3,640	4,751	1,102	3,315	1,994
77	3,122	3,720	4,860	1,127	3,396	2,046
78	3,156	3,796	4,976	1,152	3,478	2,099
79	3,190	3,870	5,088	1,179	3,562	2,149
80	3,221	3,942	5,196	1,204	3,641	2,201
81	3,255	4,019	5,306	1,227	3,723	2,254
82	3,289	4,089	5,413	1,254	3,804	2,307
83	3,329	4,156	5,519	1,279	3,887	2,360
84	3,372	4,221	5,626	1,302	3,968	2,415
85	3,403	4,271	5,717	1,324	4,042	2,464
86	3,437	4,325	5,809	1,348	4,117	2,515
87	3,467	4,382	5,906	1,367	4,192	2,567
88	3,502	4,438	6,005	1,389	4,271	2,619
89	3,539	4,491	6,098	1,412	4,345	2,670
90	3,570	4,544	6,193	1,434	4,418	2,720
91	3,604	4,600	6,285	1,457	4,497	2,770
92	3,639	4,649	6,378	1,478	4,571	2,822
93	3,675	4,701	6,465	1,498	4,643	2,872
94	3,708	4,750	6,556	1,517	4,712	2,920
95	3,746	4,799	6,642	1,539	4,783	2,966
96	3,782	4,846	6,729	1,558	4,852	3,013
97	3,819	4,899	6,817	1,579	4,921	3,061
98	3,857	4,945	6,899	1,597	4,990	3,107
99+	3,890	4,991	6,985	1,618	5,057	3,151

To calculate a household discount:

Annual premium **x** modal factor**= modal premium** (round to nearest whole cent)

Modal premium **x** discount (.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 Attained Age Premiums

For Use in ZIP Codes: 402, 410, 416-418

Male Rates

Rates effective 5/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,923	3,427	4,463	1,034	3,107	1,868
65	2,485	2,818	3,620	838	2,506	1,494
66	2,552	2,901	3,744	867	2,590	1,547
67	2,627	2,993	3,863	894	2,676	1,600
68	2,691	3,082	3,982	922	2,761	1,651
69	2,760	3,173	4,102	951	2,843	1,701
70	2,824	3,261	4,217	976	2,927	1,753
71	2,895	3,345	4,334	1,003	3,008	1,802
72	2,958	3,432	4,447	1,029	3,088	1,852
73	3,014	3,519	4,567	1,058	3,175	1,906
74	3,073	3,603	4,686	1,086	3,265	1,958
75	3,122	3,687	4,800	1,112	3,348	2,011
76	3,176	3,772	4,919	1,140	3,428	2,064
77	3,232	3,853	5,034	1,167	3,513	2,116
78	3,265	3,928	5,151	1,193	3,596	2,172
79	3,304	4,007	5,267	1,220	3,687	2,226
80	3,333	4,083	5,376	1,245	3,770	2,280
81	3,371	4,158	5,492	1,271	3,856	2,336
82	3,402	4,232	5,602	1,297	3,938	2,386
83	3,444	4,301	5,713	1,324	4,023	2,443
84	3,491	4,369	5,826	1,349	4,109	2,501
85	3,522	4,419	5,916	1,371	4,184	2,551
86	3,559	4,477	6,015	1,394	4,257	2,605
87	3,591	4,537	6,111	1,416	4,341	2,657
88	3,624	4,589	6,213	1,439	4,418	2,712
89	3,659	4,649	6,309	1,462	4,498	2,763
90	3,695	4,702	6,408	1,484	4,576	2,816
91	3,733	4,761	6,501	1,507	4,652	2,868
92	3,766	4,814	6,600	1,528	4,731	2,921
93	3,802	4,863	6,693	1,550	4,801	2,970
94	3,841	4,914	6,785	1,571	4,876	3,020
95	3,876	4,967	6,876	1,593	4,948	3,069
96	3,915	5,019	6,966	1,613	5,024	3,119
97	3,954	5,069	7,055	1,634	5,096	3,167
98	3,989	5,115	7,143	1,653	5,162	3,214
99+	4,026	5,165	7,229	1,673	5,234	3,263

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,248	3,808	4,959	1,149	3,452	2,075
65	2,760	3,129	4,025	932	2,783	1,659
66	2,841	3,230	4,161	964	2,878	1,718
67	2,915	3,329	4,293	995	2,975	1,777
68	2,993	3,426	4,429	1,026	3,066	1,837
69	3,072	3,524	4,559	1,056	3,160	1,891
70	3,142	3,624	4,686	1,086	3,251	1,946
71	3,214	3,718	4,815	1,116	3,343	2,002
72	3,289	3,813	4,942	1,144	3,435	2,055
73	3,352	3,908	5,074	1,174	3,528	2,116
74	3,411	4,001	5,206	1,206	3,626	2,176
75	3,473	4,096	5,335	1,235	3,718	2,238
76	3,532	4,187	5,464	1,266	3,810	2,294
77	3,591	4,280	5,591	1,296	3,904	2,351
78	3,625	4,368	5,725	1,325	3,996	2,413
79	3,667	4,448	5,851	1,355	4,096	2,471
80	3,705	4,537	5,974	1,385	4,189	2,532
81	3,744	4,621	6,101	1,412	4,281	2,591
82	3,782	4,702	6,224	1,441	4,371	2,652
83	3,832	4,778	6,346	1,471	4,470	2,714
84	3,876	4,856	6,470	1,496	4,566	2,777
85	3,915	4,911	6,576	1,523	4,649	2,832
86	3,954	4,974	6,684	1,548	4,733	2,892
87	3,988	5,040	6,787	1,573	4,822	2,952
88	4,026	5,100	6,907	1,599	4,908	3,012
89	4,068	5,165	7,009	1,624	4,999	3,072
90	4,104	5,226	7,119	1,649	5,082	3,129
91	4,147	5,290	7,228	1,676	5,170	3,188
92	4,186	5,345	7,335	1,699	5,254	3,245
93	4,225	5,408	7,438	1,724	5,337	3,301
94	4,265	5,461	7,538	1,746	5,419	3,357
95	4,308	5,521	7,642	1,770	5,500	3,411
96	4,348	5,575	7,738	1,792	5,581	3,464
97	4,396	5,630	7,840	1,816	5,660	3,520
98	4,438	5,684	7,933	1,837	5,737	3,573
99+	4,475	5,741	8,034	1,860	5,813	3,624

To calculate a household discount:

Annual premium **x** modal factor**= modal premium** (round to nearest whole cent)

Modal premium **x** discount (.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 Attained Age Premiums

For Use in ZIP Codes: Rest of State

Female Rates

Rates effective 5/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,210	2,591	3,374	781	2,350	1,412
65	1,878	2,129	2,736	634	1,893	1,129
66	1,930	2,199	2,832	655	1,961	1,171
67	1,983	2,267	2,919	676	2,022	1,209
68	2,034	2,332	3,013	698	2,086	1,247
69	2,086	2,400	3,098	719	2,149	1,288
70	2,135	2,463	3,188	738	2,215	1,324
71	2,187	2,531	3,275	758	2,274	1,363
72	2,236	2,592	3,362	778	2,336	1,400
73	2,276	2,657	3,453	800	2,402	1,440
74	2,321	2,722	3,541	821	2,469	1,480
75	2,361	2,785	3,633	841	2,533	1,522
76	2,401	2,850	3,718	862	2,592	1,561
77	2,442	2,915	3,808	883	2,656	1,600
78	2,470	2,970	3,894	902	2,721	1,643
79	2,495	3,027	3,980	922	2,787	1,682
80	2,521	3,085	4,066	942	2,850	1,723
81	2,548	3,145	4,150	961	2,914	1,765
82	2,572	3,199	4,236	981	2,976	1,804
83	2,604	3,251	4,321	1,001	3,042	1,849
84	2,639	3,303	4,405	1,019	3,105	1,891
85	2,663	3,342	4,473	1,036	3,163	1,929
86	2,691	3,384	4,547	1,054	3,221	1,967
87	2,715	3,428	4,619	1,071	3,279	2,009
88	2,740	3,473	4,699	1,088	3,340	2,050
89	2,768	3,515	4,771	1,105	3,399	2,090
90	2,794	3,556	4,845	1,122	3,461	2,128
91	2,822	3,599	4,917	1,139	3,517	2,169
92	2,847	3,640	4,993	1,156	3,577	2,207
93	2,878	3,680	5,062	1,173	3,632	2,244
94	2,903	3,717	5,129	1,188	3,692	2,286
95	2,932	3,755	5,200	1,204	3,744	2,321
96	2,959	3,792	5,266	1,220	3,798	2,359
97	2,989	3,831	5,333	1,236	3,852	2,395
98	3,020	3,868	5,401	1,250	3,903	2,431
99+	3,045	3,905	5,467	1,266	3,956	2,466

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,456	2,879	3,749	868	2,611	1,569
65	2,086	2,365	3,042	704	2,105	1,256
66	2,147	2,441	3,146	728	2,177	1,299
67	2,204	2,517	3,247	752	2,246	1,343
68	2,260	2,590	3,345	775	2,320	1,386
69	2,320	2,664	3,445	799	2,388	1,429
70	2,374	2,738	3,541	821	2,458	1,470
71	2,432	2,810	3,638	843	2,527	1,514
72	2,485	2,882	3,735	866	2,597	1,553
73	2,532	2,954	3,836	889	2,667	1,600
74	2,579	3,025	3,937	913	2,742	1,646
75	2,623	3,097	4,033	934	2,811	1,690
76	2,672	3,165	4,131	958	2,883	1,734
77	2,715	3,235	4,226	980	2,953	1,779
78	2,744	3,301	4,327	1,002	3,024	1,825
79	2,774	3,365	4,424	1,025	3,097	1,869
80	2,801	3,428	4,518	1,047	3,166	1,914
81	2,830	3,495	4,614	1,067	3,237	1,960
82	2,860	3,556	4,707	1,090	3,308	2,006
83	2,895	3,614	4,799	1,112	3,380	2,052
84	2,932	3,670	4,892	1,132	3,450	2,100
85	2,959	3,714	4,971	1,151	3,515	2,143
86	2,989	3,761	5,051	1,172	3,580	2,187
87	3,015	3,810	5,136	1,189	3,645	2,232
88	3,045	3,859	5,222	1,208	3,714	2,277
89	3,077	3,905	5,303	1,228	3,778	2,322
90	3,104	3,951	5,385	1,247	3,842	2,365
91	3,134	4,000	5,465	1,267	3,910	2,409
92	3,164	4,043	5,546	1,285	3,975	2,454
93	3,196	4,088	5,622	1,303	4,037	2,497
94	3,224	4,130	5,701	1,319	4,097	2,539
95	3,257	4,173	5,776	1,338	4,159	2,579
96	3,289	4,214	5,851	1,355	4,219	2,620
97	3,321	4,260	5,928	1,373	4,279	2,662
98	3,354	4,300	5,999	1,389	4,339	2,702
99+	3,383	4,340	6,074	1,407	4,397	2,740

To calculate a household discount:

Annual premium **x** modal factor**= modal premium** (round to nearest whole cent)

Modal premium **x** discount (.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 Attained Age Premiums

For Use in ZIP Codes: Rest of State

Male Rates

Rates effective 5/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,542	2,980	3,881	899	2,702	1,624
65	2,161	2,450	3,148	729	2,179	1,299
66	2,219	2,523	3,256	754	2,252	1,345
67	2,284	2,603	3,359	777	2,327	1,391
68	2,340	2,680	3,463	802	2,401	1,436
69	2,400	2,759	3,567	827	2,472	1,479
70	2,456	2,836	3,667	849	2,545	1,524
71	2,517	2,909	3,769	872	2,616	1,567
72	2,572	2,984	3,867	895	2,685	1,610
73	2,621	3,060	3,971	920	2,761	1,657
74	2,672	3,133	4,075	944	2,839	1,703
75	2,715	3,206	4,174	967	2,911	1,749
76	2,762	3,280	4,277	991	2,981	1,795
77	2,810	3,350	4,377	1,015	3,055	1,840
78	2,839	3,416	4,479	1,037	3,127	1,889
79	2,873	3,484	4,580	1,061	3,206	1,936
80	2,898	3,550	4,675	1,083	3,278	1,983
81	2,931	3,616	4,776	1,105	3,353	2,031
82	2,958	3,680	4,871	1,128	3,424	2,075
83	2,995	3,740	4,968	1,151	3,498	2,124
84	3,036	3,799	5,066	1,173	3,573	2,175
85	3,063	3,843	5,144	1,192	3,638	2,218
86	3,095	3,893	5,230	1,212	3,702	2,265
87	3,123	3,945	5,314	1,231	3,775	2,310
88	3,151	3,990	5,403	1,251	3,842	2,358
89	3,182	4,043	5,486	1,271	3,911	2,403
90	3,213	4,089	5,572	1,290	3,979	2,449
91	3,246	4,140	5,653	1,310	4,045	2,494
92	3,275	4,186	5,739	1,329	4,114	2,540
93	3,306	4,229	5,820	1,348	4,175	2,583
94	3,340	4,273	5,900	1,366	4,240	2,626
95	3,370	4,319	5,979	1,385	4,303	2,669
96	3,404	4,364	6,057	1,403	4,369	2,712
97	3,438	4,408	6,135	1,421	4,431	2,754
98	3,469	4,448	6,211	1,437	4,489	2,795
99+	3,501	4,491	6,286	1,455	4,551	2,837

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,824	3,311	4,312	999	3,002	1,804
65	2,400	2,721	3,500	810	2,420	1,443
66	2,470	2,809	3,618	838	2,503	1,494
67	2,535	2,895	3,733	865	2,587	1,545
68	2,603	2,979	3,851	892	2,666	1,597
69	2,671	3,064	3,964	918	2,748	1,644
70	2,732	3,151	4,075	944	2,827	1,692
71	2,795	3,233	4,187	970	2,907	1,741
72	2,860	3,316	4,297	995	2,987	1,787
73	2,915	3,398	4,412	1,021	3,068	1,840
74	2,966	3,479	4,527	1,049	3,153	1,892
75	3,020	3,562	4,639	1,074	3,233	1,946
76	3,071	3,641	4,751	1,101	3,313	1,995
77	3,123	3,722	4,862	1,127	3,395	2,044
78	3,152	3,798	4,978	1,152	3,475	2,098
79	3,189	3,868	5,088	1,178	3,562	2,149
80	3,222	3,945	5,195	1,204	3,643	2,202
81	3,256	4,018	5,305	1,228	3,723	2,253
82	3,289	4,089	5,412	1,253	3,801	2,306
83	3,332	4,155	5,518	1,279	3,887	2,360
84	3,370	4,223	5,626	1,301	3,970	2,415
85	3,404	4,270	5,718	1,324	4,043	2,463
86	3,438	4,325	5,812	1,346	4,116	2,515
87	3,468	4,383	5,902	1,368	4,193	2,567
88	3,501	4,435	6,006	1,390	4,268	2,619
89	3,537	4,491	6,095	1,412	4,347	2,671
90	3,569	4,544	6,190	1,434	4,419	2,721
91	3,606	4,600	6,285	1,457	4,496	2,772
92	3,640	4,648	6,378	1,477	4,569	2,822
93	3,674	4,703	6,468	1,499	4,641	2,870
94	3,709	4,749	6,555	1,518	4,712	2,919
95	3,746	4,801	6,645	1,539	4,783	2,966
96	3,781	4,848	6,729	1,558	4,853	3,012
97	3,823	4,896	6,817	1,579	4,922	3,061
98	3,859	4,943	6,898	1,597	4,989	3,107
99+	3,891	4,992	6,986	1,617	5,055	3,151

To calculate a household discount:

Annual premium **x** modal factor**= modal premium** (round to nearest whole cent)

Modal premium **x** discount (.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 Health and Life Insurance Company Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (b) be someone with whom you are in a civil union partnership; or (c) be a permanent resident in your home. 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, the discount shall remain in effect for the life of the policy.

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 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	$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.

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

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.

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.

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

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 $2,800 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.

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

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

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.

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

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 $1,632	$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.

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

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