Outline of coverage

Medicare Supplement Insurance

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

Missouri

Underwritten by

Aetna Health and Life Insurance Company

AetnaSeniorProducts.com

AHLMS04997MO

Rates effective: 07/2026 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. 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 2026[2]					**$8,000**[2]	**$4,000**[2]				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,950** before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

Aetna Health and Life Insurance Company

Annual Premiums

Zip Codes: 630-631, 633, 640-641

Female Rates

Rates effective 7/1/2026

ISSUE AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,928	3,967	5,413	933	3,444	3,248
65	3,080	3,764	4,441	782	3,151	3,003
66	3,105	3,790	4,473	788	3,175	3,039
67	3,153	3,855	4,549	802	3,229	3,105
68	3,219	3,938	4,646	819	3,296	3,186
69	3,300	4,032	4,758	839	3,377	3,277
70	3,381	4,135	4,876	860	3,461	3,362
71	3,466	4,240	5,001	881	3,548	3,450
72	3,555	4,346	5,128	903	3,640	3,535
73	3,642	4,454	5,254	926	3,732	3,621
74	3,736	4,572	5,392	950	3,827	3,709
75	3,830	4,685	5,525	973	3,923	3,804
76	3,926	4,798	5,663	999	4,017	3,892
77	4,024	4,920	5,807	1,023	4,118	3,986
78	4,118	5,038	5,943	1,047	4,216	4,086
79	4,208	5,148	6,073	1,070	4,309	4,175
80	4,308	5,266	6,214	1,094	4,406	4,274
81	4,406	5,387	6,357	1,120	4,511	4,374
82	4,500	5,506	6,492	1,145	4,607	4,469
83	4,604	5,629	6,645	1,170	4,715	4,571
84	4,704	5,750	6,789	1,195	4,816	4,669
85	4,837	5,918	6,983	1,230	4,953	4,804
86	4,941	6,041	7,130	1,256	5,059	4,904
87	5,046	6,170	7,278	1,284	5,167	5,006
88	5,150	6,297	7,428	1,309	5,272	5,113
89	5,257	6,427	7,582	1,337	5,378	5,216
90	5,364	6,559	7,739	1,363	5,489	5,321
91	5,470	6,688	7,890	1,390	5,600	5,429
92	5,575	6,816	8,046	1,418	5,709	5,535
93	5,684	6,946	8,196	1,445	5,821	5,639
94	5,787	7,074	8,348	1,471	5,925	5,743
95	5,886	7,195	8,494	1,496	6,026	5,840
96	5,975	7,307	8,623	1,519	6,120	5,935
97	6,056	7,405	8,742	1,539	6,200	6,010
98	6,122	7,482	8,830	1,557	6,265	6,074
99+	6,156	7,526	8,885	1,566	6,303	6,111

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,365	4,408	6,014	1,036	3,826	3,608
65	3,420	4,179	4,932	869	3,499	3,335
66	3,450	4,215	4,972	876	3,531	3,373
67	3,506	4,285	5,056	892	3,586	3,446
68	3,577	4,377	5,162	908	3,662	3,539
69	3,668	4,478	5,290	933	3,751	3,640
70	3,761	4,595	5,421	955	3,848	3,739
71	3,852	4,710	5,556	979	3,945	3,832
72	3,949	4,829	5,700	1,004	4,043	3,930
73	4,045	4,946	5,839	1,028	4,146	4,023
74	4,154	5,080	5,990	1,055	4,252	4,122
75	4,256	5,208	6,141	1,082	4,359	4,222
76	4,361	5,331	6,291	1,109	4,464	4,322
77	4,473	5,469	6,451	1,137	4,576	4,430
78	4,575	5,596	6,604	1,164	4,684	4,537
79	4,677	5,719	6,746	1,188	4,788	4,637
80	4,785	5,852	6,903	1,216	4,897	4,749
81	4,898	5,989	7,064	1,244	5,015	4,857
82	5,002	6,115	7,217	1,272	5,122	4,962
83	5,120	6,257	7,383	1,301	5,238	5,080
84	5,228	6,390	7,541	1,328	5,350	5,188
85	5,377	6,574	7,759	1,366	5,500	5,337
86	5,490	6,712	7,921	1,396	5,621	5,450
87	5,607	6,853	8,089	1,426	5,740	5,564
88	5,723	7,000	8,254	1,454	5,860	5,678
89	5,840	7,142	8,428	1,485	5,977	5,795
90	5,960	7,284	8,597	1,513	6,097	5,911
91	6,077	7,428	8,767	1,546	6,223	6,032
92	6,195	7,579	8,939	1,575	6,344	6,151
93	6,311	7,720	9,108	1,605	6,464	6,265
94	6,429	7,860	9,278	1,634	6,582	6,380
95	6,539	7,991	9,435	1,661	6,691	6,489
96	6,639	8,120	9,584	1,688	6,800	6,593
97	6,731	8,232	9,712	1,711	6,889	6,680
98	6,800	8,315	9,811	1,728	6,961	6,747
99+	6,841	8,364	9,871	1,739	7,002	6,787

The above rates do not include the $20 application fee.

To calculate a 7% 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 Premiums

Zip Codes: 630-631, 633, 640-641

Male Rates

Rates effective 7/1/2026

ISSUE AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,517	4,562	6,225	1,073	3,959	3,735
65	3,540	4,325	5,105	900	3,623	3,452
66	3,569	4,360	5,143	906	3,651	3,493
67	3,628	4,435	5,230	922	3,709	3,569
68	3,700	4,527	5,340	942	3,789	3,661
69	3,796	4,637	5,475	965	3,883	3,769
70	3,892	4,756	5,610	988	3,980	3,870
71	3,989	4,876	5,751	1,014	4,079	3,967
72	4,087	4,999	5,899	1,039	4,184	4,066
73	4,185	5,123	6,044	1,064	4,287	4,168
74	4,299	5,260	6,198	1,093	4,399	4,272
75	4,406	5,387	6,356	1,120	4,511	4,372
76	4,514	5,518	6,512	1,148	4,622	4,476
77	4,628	5,660	6,681	1,176	4,736	4,588
78	4,733	5,793	6,833	1,205	4,850	4,696
79	4,837	5,919	6,983	1,230	4,955	4,799
80	4,953	6,055	7,144	1,258	5,067	4,913
81	5,067	6,194	7,310	1,289	5,187	5,027
82	5,176	6,330	7,466	1,316	5,298	5,136
83	5,296	6,477	7,642	1,346	5,419	5,255
84	5,408	6,615	7,804	1,375	5,536	5,369
85	5,564	6,805	8,028	1,416	5,697	5,524
86	5,684	6,946	8,197	1,444	5,821	5,639
87	5,804	7,095	8,369	1,476	5,943	5,758
88	5,920	7,242	8,546	1,505	6,065	5,878
89	6,048	7,392	8,723	1,537	6,188	5,999
90	6,170	7,540	8,897	1,567	6,312	6,117
91	6,289	7,692	9,073	1,598	6,440	6,243
92	6,411	7,840	9,253	1,631	6,567	6,365
93	6,534	7,989	9,426	1,661	6,690	6,485
94	6,658	8,138	9,598	1,692	6,813	6,604
95	6,772	8,279	9,763	1,720	6,929	6,719
96	6,873	8,404	9,918	1,746	7,039	6,821
97	6,966	8,516	10,049	1,770	7,132	6,914
98	7,035	8,606	10,153	1,789	7,205	6,984
99+	7,082	8,655	10,213	1,800	7,249	7,027

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	5,020	5,068	6,917	1,192	4,402	4,148
65	3,932	4,807	5,672	1,000	4,028	3,833
66	3,963	4,841	5,719	1,008	4,059	3,882
67	4,031	4,926	5,815	1,026	4,124	3,966
68	4,114	5,032	5,935	1,044	4,211	4,071
69	4,218	5,152	6,080	1,073	4,318	4,187
70	4,322	5,282	6,235	1,100	4,425	4,300
71	4,430	5,416	6,393	1,124	4,536	4,408
72	4,545	5,555	6,556	1,155	4,651	4,517
73	4,655	5,691	6,713	1,183	4,766	4,626
74	4,779	5,841	6,892	1,215	4,889	4,744
75	4,897	5,989	7,063	1,243	5,015	4,857
76	5,018	6,130	7,239	1,276	5,134	4,975
77	5,143	6,288	7,418	1,306	5,263	5,096
78	5,263	6,433	7,591	1,338	5,385	5,217
79	5,378	6,580	7,759	1,366	5,508	5,336
80	5,501	6,727	7,937	1,398	5,634	5,458
81	5,629	6,884	8,124	1,431	5,764	5,585
82	5,750	7,031	8,300	1,463	5,887	5,708
83	5,886	7,195	8,488	1,496	6,024	5,840
84	6,013	7,352	8,673	1,527	6,153	5,965
85	6,178	7,561	8,924	1,572	6,330	6,136
86	6,311	7,720	9,108	1,605	6,462	6,265
87	6,450	7,884	9,302	1,640	6,602	6,400
88	6,581	8,046	9,494	1,672	6,737	6,531
89	6,716	8,211	9,692	1,707	6,875	6,664
90	6,853	8,380	9,886	1,740	7,013	6,800
91	6,990	8,542	10,081	1,776	7,157	6,935
92	7,129	8,711	10,277	1,810	7,299	7,072
93	7,260	8,878	10,475	1,847	7,436	7,206
94	7,394	9,041	10,670	1,879	7,570	7,338
95	7,517	9,194	10,848	1,911	7,699	7,460
96	7,636	9,340	11,020	1,941	7,820	7,580
97	7,736	9,467	11,168	1,968	7,925	7,682
98	7,820	9,564	11,283	1,988	8,006	7,760
99+	7,869	9,617	11,351	2,000	8,054	7,808

The above rates do not include the $20 application fee.

To calculate a 7% 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 Premiums

Zip Codes: Rest of State

Female Rates

Rates effective 7/1/2026

ISSUE AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,507	3,542	4,833	833	3,075	2,900
65	2,750	3,361	3,965	698	2,813	2,681
66	2,772	3,384	3,994	704	2,835	2,713
67	2,815	3,442	4,062	716	2,883	2,772
68	2,874	3,516	4,148	731	2,943	2,845
69	2,946	3,600	4,248	749	3,015	2,926
70	3,019	3,692	4,354	768	3,090	3,002
71	3,095	3,786	4,465	787	3,168	3,080
72	3,174	3,880	4,579	806	3,250	3,156
73	3,252	3,977	4,691	827	3,332	3,233
74	3,336	4,082	4,814	848	3,417	3,312
75	3,420	4,183	4,933	869	3,503	3,396
76	3,505	4,284	5,056	892	3,587	3,475
77	3,593	4,393	5,185	913	3,677	3,559
78	3,677	4,498	5,306	935	3,764	3,648
79	3,757	4,596	5,422	955	3,847	3,728
80	3,846	4,702	5,548	977	3,934	3,816
81	3,934	4,810	5,676	1,000	4,028	3,905
82	4,018	4,916	5,796	1,022	4,113	3,990
83	4,111	5,026	5,933	1,045	4,210	4,081
84	4,200	5,134	6,062	1,067	4,300	4,169
85	4,319	5,284	6,235	1,098	4,422	4,289
86	4,412	5,394	6,366	1,121	4,517	4,379
87	4,505	5,509	6,498	1,146	4,613	4,470
88	4,598	5,622	6,632	1,169	4,707	4,565
89	4,694	5,738	6,770	1,194	4,802	4,657
90	4,789	5,856	6,910	1,217	4,901	4,751
91	4,884	5,971	7,045	1,241	5,000	4,847
92	4,978	6,086	7,184	1,266	5,097	4,942
93	5,075	6,202	7,318	1,290	5,197	5,035
94	5,167	6,316	7,454	1,313	5,290	5,128
95	5,255	6,424	7,584	1,336	5,380	5,214
96	5,335	6,524	7,699	1,356	5,464	5,299
97	5,407	6,612	7,805	1,374	5,536	5,366
98	5,466	6,680	7,884	1,390	5,594	5,423
99+	5,496	6,720	7,933	1,398	5,628	5,456

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,897	3,936	5,370	925	3,416	3,221
65	3,054	3,731	4,404	776	3,124	2,978
66	3,080	3,763	4,439	782	3,153	3,012
67	3,130	3,826	4,514	796	3,202	3,077
68	3,194	3,908	4,609	811	3,270	3,160
69	3,275	3,998	4,723	833	3,349	3,250
70	3,358	4,103	4,840	853	3,436	3,338
71	3,439	4,205	4,961	874	3,522	3,421
72	3,526	4,312	5,089	896	3,610	3,509
73	3,612	4,416	5,213	918	3,702	3,592
74	3,709	4,536	5,348	942	3,796	3,680
75	3,800	4,650	5,483	966	3,892	3,770
76	3,894	4,760	5,617	990	3,986	3,859
77	3,994	4,883	5,760	1,015	4,086	3,955
78	4,085	4,996	5,896	1,039	4,182	4,051
79	4,176	5,106	6,023	1,061	4,275	4,140
80	4,272	5,225	6,163	1,086	4,372	4,240
81	4,373	5,347	6,307	1,111	4,478	4,337
82	4,466	5,460	6,444	1,136	4,573	4,430
83	4,571	5,587	6,592	1,162	4,677	4,536
84	4,668	5,705	6,733	1,186	4,777	4,632
85	4,801	5,870	6,928	1,220	4,911	4,765
86	4,902	5,993	7,072	1,246	5,019	4,866
87	5,006	6,119	7,222	1,273	5,125	4,968
88	5,110	6,250	7,370	1,298	5,232	5,070
89	5,214	6,377	7,525	1,326	5,337	5,174
90	5,321	6,504	7,676	1,351	5,444	5,278
91	5,426	6,632	7,828	1,380	5,556	5,386
92	5,531	6,767	7,981	1,406	5,664	5,492
93	5,635	6,893	8,132	1,433	5,771	5,594
94	5,740	7,018	8,284	1,459	5,877	5,696
95	5,838	7,135	8,424	1,483	5,974	5,794
96	5,928	7,250	8,557	1,507	6,071	5,887
97	6,010	7,350	8,671	1,528	6,151	5,964
98	6,071	7,424	8,760	1,543	6,215	6,024
99+	6,108	7,468	8,813	1,553	6,252	6,060

The above rates do not include the $20 application fee.

To calculate a 7% 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 Premiums

Zip Codes: Rest of State

Male Rates

Rates effective 7/1/2026

ISSUE AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,033	4,073	5,558	958	3,535	3,335
65	3,161	3,862	4,558	804	3,235	3,082
66	3,187	3,893	4,592	809	3,260	3,119
67	3,239	3,960	4,670	823	3,312	3,187
68	3,304	4,042	4,768	841	3,383	3,269
69	3,389	4,140	4,888	862	3,467	3,365
70	3,475	4,246	5,009	882	3,554	3,455
71	3,562	4,354	5,135	905	3,642	3,542
72	3,649	4,463	5,267	928	3,736	3,630
73	3,737	4,574	5,396	950	3,828	3,721
74	3,838	4,696	5,534	976	3,928	3,814
75	3,934	4,810	5,675	1,000	4,028	3,904
76	4,030	4,927	5,814	1,025	4,127	3,996
77	4,132	5,054	5,965	1,050	4,229	4,096
78	4,226	5,172	6,101	1,076	4,330	4,193
79	4,319	5,285	6,235	1,098	4,424	4,285
80	4,422	5,406	6,379	1,123	4,524	4,387
81	4,524	5,530	6,527	1,151	4,631	4,488
82	4,621	5,652	6,666	1,175	4,730	4,586
83	4,729	5,783	6,823	1,202	4,838	4,692
84	4,829	5,906	6,968	1,228	4,943	4,794
85	4,968	6,076	7,168	1,264	5,087	4,932
86	5,075	6,202	7,319	1,289	5,197	5,035
87	5,182	6,335	7,472	1,318	5,306	5,141
88	5,286	6,466	7,630	1,344	5,415	5,248
89	5,400	6,600	7,788	1,372	5,525	5,356
90	5,509	6,732	7,944	1,399	5,636	5,462
91	5,615	6,868	8,101	1,427	5,750	5,574
92	5,724	7,000	8,262	1,456	5,863	5,683
93	5,834	7,133	8,416	1,483	5,973	5,790
94	5,945	7,266	8,570	1,511	6,083	5,896
95	6,046	7,392	8,717	1,536	6,187	5,999
96	6,137	7,504	8,855	1,559	6,285	6,090
97	6,220	7,604	8,972	1,580	6,368	6,173
98	6,281	7,684	9,065	1,597	6,433	6,236
99+	6,323	7,728	9,119	1,607	6,472	6,274

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,482	4,525	6,176	1,064	3,930	3,704
65	3,511	4,292	5,064	893	3,596	3,422
66	3,538	4,322	5,106	900	3,624	3,466
67	3,599	4,398	5,192	916	3,682	3,541
68	3,673	4,493	5,299	932	3,760	3,635
69	3,766	4,600	5,429	958	3,855	3,738
70	3,859	4,716	5,567	982	3,951	3,839
71	3,955	4,836	5,708	1,004	4,050	3,936
72	4,058	4,960	5,854	1,031	4,153	4,033
73	4,156	5,081	5,994	1,056	4,255	4,130
74	4,267	5,215	6,154	1,085	4,365	4,236
75	4,372	5,347	6,306	1,110	4,478	4,337
76	4,480	5,473	6,463	1,139	4,584	4,442
77	4,592	5,614	6,623	1,166	4,699	4,550
78	4,699	5,744	6,778	1,195	4,808	4,658
79	4,802	5,875	6,928	1,220	4,918	4,764
80	4,912	6,006	7,087	1,248	5,030	4,873
81	5,026	6,146	7,254	1,278	5,146	4,987
82	5,134	6,278	7,411	1,306	5,256	5,096
83	5,255	6,424	7,579	1,336	5,379	5,214
84	5,369	6,564	7,744	1,363	5,494	5,326
85	5,516	6,751	7,968	1,404	5,652	5,479
86	5,635	6,893	8,132	1,433	5,770	5,594
87	5,759	7,039	8,305	1,464	5,895	5,714
88	5,876	7,184	8,477	1,493	6,015	5,831
89	5,996	7,331	8,654	1,524	6,138	5,950
90	6,119	7,482	8,827	1,554	6,262	6,071
91	6,241	7,627	9,001	1,586	6,390	6,192
92	6,365	7,778	9,176	1,616	6,517	6,314
93	6,482	7,927	9,353	1,649	6,639	6,434
94	6,602	8,072	9,527	1,678	6,759	6,552
95	6,712	8,209	9,686	1,706	6,874	6,661
96	6,818	8,339	9,839	1,733	6,982	6,768
97	6,907	8,453	9,971	1,757	7,076	6,859
98	6,982	8,539	10,074	1,775	7,148	6,929
99+	7,026	8,587	10,135	1,786	7,191	6,971

The above rates do not include the $20 application fee.

To calculate a 7% 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 may be changed for this policy on any premium due date, provided premiums for all policies issued on this form number in your state are also changed. For every nonscheduled premium change, we will give you at least 30 days advance notice in writing of such premium change. 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; or (b) be 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 BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$0	$1,736 (Part A Deductible)
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	$0	Up to $217 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

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

*Once you have been billed $283 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	$0	Up to $217 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

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

*Once you have been billed $283 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

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

*Once you have been billed $283 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $283 of Medicare-Approved amounts*	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $283 of Medicare-Approved amounts*	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $283 of Medicare-Approved amounts*	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE PLAN F

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

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

****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,950 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,950. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,950 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,950 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $283 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,950 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,950. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,950 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,950 DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $283 of Medicare-Approved amounts*	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $283 of Medicare-Approved amounts*	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,950 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,950 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $283 of Medicare-Approved amounts*	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,950 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,950 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

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

*Once you have been billed $283 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

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

*Once you have been billed $283 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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