aetna®

Aetna Health and Life Insurance Company

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Outline of Coverage

Medicare Supplement Insurance

BENEFIT PLANS A, B, F, HIGH DEDUCTIBLE F, G, N

Underwritten by

Aetna Health and Life Insurance Company

Nevada

AHLMS03848NV

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Rates Effective: 08/2019 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

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A" Some plans may not be available in your state.

Basic Benefits:
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-Approved expenses) or, copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of coinsurance or copayments
Blood: First three pints of blood each year.
Hospice-Part A coinsurance

A	B	C	D	F/F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $5,560; paid at 100% after limit reached	Out-of-pocket limit $2,780; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2,300. 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.

Aetna Health and Life Insurance Company

Annual Premiums

For Use in ZIP Codes: 889-891

Female Rates

Rates Effective 8/1/2019

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,592	1,732	2,158	863	1,655	1,112
66	1,592	1,732	2,158	863	1,655	1,147
67	1,592	1,732	2,158	863	1,655	1,183
68	1,612	1,753	2,184	874	1,675	1,231
69	1,646	1,790	2,230	892	1,710	1,294
70	1,689	1,837	2,289	916	1,755	1,365
71	1,740	1,892	2,359	944	1,809	1,407
72	1,794	1,952	2,432	973	1,864	1,450
73	1,853	2,014	2,511	1,004	1,926	1,497
74	1,918	2,085	2,598	1,039	1,994	1,550
75	1,987	2,161	2,695	1,078	2,066	1,607
76	2,057	2,237	2,789	1,117	2,138	1,662
77	2,127	2,313	2,884	1,152	2,210	1,719
78	2,197	2,389	2,976	1,191	2,283	1,776
79	2,269	2,467	3,075	1,229	2,357	1,832
80	2,339	2,543	3,170	1,268	2,431	1,890
81	2,414	2,624	3,270	1,308	2,508	1,950
82	2,488	2,708	3,372	1,348	2,586	2,010
83	2,565	2,790	3,477	1,390	2,667	2,073
84	2,643	2,875	3,582	1,433	2,748	2,136
85	2,736	2,974	3,707	1,484	2,843	2,211
86	2,813	3,061	3,815	1,526	2,925	2,273
87	2,892	3,148	3,921	1,569	3,008	2,338
88	2,974	3,236	4,033	1,614	3,091	2,403
89	3,057	3,325	4,143	1,658	3,177	2,470
90	3,141	3,417	4,257	1,704	3,265	2,539
91	3,227	3,510	4,374	1,749	3,353	2,607
92	3,313	3,604	4,491	1,796	3,444	2,678
93	3,402	3,701	4,611	1,844	3,536	2,749
94	3,493	3,797	4,733	1,893	3,629	2,822
95	3,582	3,897	4,856	1,942	3,724	2,895
96	3,675	3,997	4,982	1,993	3,820	2,969
97	3,770	4,100	5,109	2,043	3,918	3,046
98	3,865	4,203	5,238	2,096	4,017	3,123
99+	3,963	4,309	5,369	2,148	4,118	3,201

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,768	1,925	2,398	959	1,838	1,237
66	1,768	1,925	2,398	959	1,838	1,274
67	1,768	1,925	2,398	959	1,838	1,313
68	1,791	1,948	2,426	971	1,861	1,368
69	1,828	1,987	2,478	993	1,901	1,439
70	1,877	2,041	2,543	1,018	1,950	1,516
71	1,934	2,103	2,621	1,049	2,010	1,564
72	1,994	2,169	2,702	1,080	2,071	1,611
73	2,058	2,239	2,790	1,117	2,139	1,663
74	2,131	2,318	2,888	1,155	2,215	1,723
75	2,208	2,402	2,993	1,198	2,295	1,785
76	2,286	2,487	3,100	1,240	2,377	1,848
77	2,362	2,570	3,204	1,281	2,456	1,909
78	2,440	2,654	3,307	1,323	2,537	1,972
79	2,521	2,741	3,415	1,367	2,618	2,036
80	2,598	2,826	3,524	1,409	2,701	2,100
81	2,681	2,916	3,633	1,454	2,786	2,166
82	2,765	3,008	3,747	1,498	2,873	2,235
83	2,849	3,101	3,863	1,544	2,962	2,304
84	2,937	3,195	3,981	1,592	3,053	2,373
85	3,038	3,306	4,118	1,648	3,159	2,456
86	3,126	3,401	4,238	1,695	3,250	2,527
87	3,213	3,498	4,358	1,743	3,342	2,598
88	3,306	3,596	4,480	1,792	3,434	2,671
89	3,397	3,695	4,604	1,840	3,531	2,744
90	3,491	3,796	4,729	1,893	3,628	2,821
91	3,586	3,899	4,859	1,943	3,726	2,897
92	3,683	4,006	4,990	1,997	3,826	2,975
93	3,780	4,113	5,122	2,050	3,928	3,054
94	3,879	4,220	5,259	2,104	4,033	3,135
95	3,981	4,331	5,396	2,158	4,137	3,218
96	4,083	4,442	5,536	2,214	4,244	3,300
97	4,188	4,555	5,678	2,271	4,353	3,384
98	4,295	4,670	5,820	2,328	4,464	3,470
99+	4,402	4,787	5,966	2,387	4,575	3,556

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 a 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 and Life Insurance Company

Annual Premiums

For Use in ZIP Codes: 889-891

Male Rates

Rates Effective 8/1/2019

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,832	1,992	2,481	994	1,903	1,279
66	1,832	1,992	2,481	994	1,903	1,320
67	1,832	1,992	2,481	994	1,903	1,360
68	1,853	2,015	2,511	1,004	1,927	1,416
69	1,893	2,057	2,565	1,026	1,967	1,488
70	1,942	2,112	2,631	1,053	2,019	1,569
71	2,001	2,176	2,713	1,084	2,080	1,618
72	2,064	2,244	2,797	1,119	2,145	1,669
73	2,131	2,318	2,888	1,155	2,215	1,722
74	2,205	2,398	2,988	1,196	2,293	1,783
75	2,285	2,487	3,100	1,240	2,376	1,848
76	2,366	2,573	3,208	1,283	2,459	1,912
77	2,445	2,660	3,315	1,325	2,541	1,977
78	2,525	2,746	3,424	1,369	2,625	2,041
79	2,609	2,837	3,535	1,415	2,711	2,107
80	2,691	2,926	3,646	1,458	2,796	2,173
81	2,775	3,018	3,762	1,503	2,884	2,242
82	2,861	3,114	3,877	1,550	2,973	2,312
83	2,948	3,209	3,998	1,598	3,066	2,385
84	3,039	3,307	4,120	1,648	3,159	2,456
85	3,145	3,421	4,263	1,706	3,269	2,542
86	3,236	3,520	4,386	1,755	3,363	2,615
87	3,326	3,620	4,509	1,805	3,459	2,689
88	3,421	3,721	4,636	1,855	3,555	2,764
89	3,515	3,823	4,765	1,906	3,654	2,839
90	3,614	3,930	4,896	1,959	3,755	2,919
91	3,712	4,037	5,030	2,011	3,857	2,998
92	3,811	4,144	5,165	2,066	3,961	3,079
93	3,913	4,256	5,304	2,122	4,066	3,161
94	4,015	4,368	5,442	2,177	4,173	3,245
95	4,120	4,481	5,585	2,233	4,283	3,331
96	4,227	4,598	5,729	2,292	4,393	3,415
97	4,335	4,715	5,876	2,350	4,506	3,504
98	4,444	4,834	6,024	2,409	4,619	3,591
99+	4,555	4,955	6,175	2,470	4,736	3,681

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	2,035	2,213	2,758	1,103	2,114	1,421
66	2,035	2,213	2,758	1,103	2,114	1,467
67	2,035	2,213	2,758	1,103	2,114	1,511
68	2,058	2,240	2,790	1,117	2,139	1,572
69	2,103	2,285	2,848	1,142	2,185	1,655
70	2,158	2,348	2,926	1,171	2,243	1,744
71	2,225	2,419	3,014	1,205	2,311	1,798
72	2,293	2,494	3,108	1,242	2,382	1,853
73	2,367	2,575	3,209	1,283	2,461	1,913
74	2,451	2,665	3,322	1,327	2,547	1,981
75	2,539	2,762	3,443	1,377	2,640	2,053
76	2,629	2,860	3,564	1,426	2,733	2,125
77	2,716	2,957	3,684	1,473	2,825	2,196
78	2,806	3,052	3,803	1,521	2,918	2,268
79	2,899	3,153	3,927	1,571	3,011	2,343
80	2,988	3,251	4,052	1,620	3,106	2,415
81	3,082	3,353	4,180	1,672	3,204	2,492
82	3,180	3,458	4,309	1,722	3,304	2,569
83	3,278	3,566	4,442	1,777	3,406	2,649
84	3,378	3,674	4,578	1,832	3,511	2,729
85	3,495	3,802	4,736	1,895	3,633	2,824
86	3,595	3,912	4,873	1,950	3,738	2,905
87	3,697	4,022	5,012	2,003	3,843	2,988
88	3,802	4,135	5,152	2,060	3,950	3,072
89	3,905	4,251	5,294	2,116	4,060	3,156
90	4,014	4,365	5,439	2,177	4,172	3,244
91	4,123	4,485	5,588	2,235	4,285	3,331
92	4,235	4,606	5,738	2,297	4,400	3,421
93	4,348	4,729	5,891	2,357	4,518	3,512
94	4,461	4,854	6,047	2,420	4,636	3,606
95	4,578	4,980	6,206	2,481	4,758	3,700
96	4,696	5,108	6,367	2,547	4,881	3,795
97	4,817	5,239	6,530	2,611	5,007	3,892
98	4,940	5,370	6,693	2,677	5,132	3,991
99+	5,062	5,506	6,861	2,744	5,261	4,090

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 a 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 and Life Insurance Company

Annual Premiums

For Use in: Rest of State

Female Rates

Rates Effective 8/1/2019

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,474	1,604	1,998	799	1,532	1,030
66	1,474	1,604	1,998	799	1,532	1,062
67	1,474	1,604	1,998	799	1,532	1,095
68	1,493	1,623	2,022	809	1,551	1,140
69	1,524	1,657	2,065	826	1,583	1,198
70	1,564	1,701	2,119	848	1,625	1,264
71	1,611	1,752	2,184	874	1,675	1,303
72	1,661	1,807	2,252	901	1,726	1,343
73	1,716	1,865	2,325	930	1,783	1,386
74	1,776	1,931	2,406	962	1,846	1,435
75	1,840	2,001	2,495	998	1,913	1,488
76	1,905	2,071	2,582	1,034	1,980	1,539
77	1,969	2,142	2,670	1,067	2,046	1,592
78	2,034	2,212	2,756	1,103	2,114	1,644
79	2,101	2,284	2,847	1,138	2,182	1,696
80	2,166	2,355	2,935	1,174	2,251	1,750
81	2,235	2,430	3,028	1,211	2,322	1,806
82	2,304	2,507	3,122	1,248	2,394	1,861
83	2,375	2,583	3,219	1,287	2,469	1,919
84	2,447	2,662	3,317	1,327	2,544	1,978
85	2,533	2,754	3,432	1,374	2,632	2,047
86	2,605	2,834	3,532	1,413	2,708	2,105
87	2,678	2,915	3,631	1,453	2,785	2,165
88	2,754	2,996	3,734	1,494	2,862	2,225
89	2,831	3,079	3,836	1,535	2,942	2,287
90	2,908	3,164	3,942	1,578	3,023	2,351
91	2,988	3,250	4,050	1,619	3,105	2,414
92	3,068	3,337	4,158	1,663	3,189	2,480
93	3,150	3,427	4,269	1,707	3,274	2,545
94	3,234	3,516	4,382	1,753	3,360	2,613
95	3,317	3,608	4,496	1,798	3,448	2,681
96	3,403	3,701	4,613	1,845	3,537	2,749
97	3,491	3,796	4,731	1,892	3,628	2,820
98	3,579	3,892	4,850	1,941	3,719	2,892
99+	3,669	3,990	4,971	1,989	3,813	2,964

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,637	1,782	2,220	888	1,702	1,145
66	1,637	1,782	2,220	888	1,702	1,180
67	1,637	1,782	2,220	888	1,702	1,216
68	1,658	1,804	2,246	899	1,723	1,267
69	1,693	1,840	2,294	919	1,760	1,332
70	1,738	1,890	2,355	943	1,806	1,404
71	1,791	1,947	2,427	971	1,861	1,448
72	1,846	2,008	2,502	1,000	1,918	1,492
73	1,906	2,073	2,583	1,034	1,981	1,540
74	1,973	2,146	2,674	1,069	2,051	1,595
75	2,044	2,224	2,771	1,109	2,125	1,653
76	2,117	2,303	2,870	1,148	2,201	1,711
77	2,187	2,380	2,967	1,186	2,274	1,768
78	2,259	2,457	3,062	1,225	2,349	1,826
79	2,334	2,538	3,162	1,266	2,424	1,885
80	2,406	2,617	3,263	1,305	2,501	1,944
81	2,482	2,700	3,364	1,346	2,580	2,006
82	2,560	2,785	3,469	1,387	2,660	2,069
83	2,638	2,871	3,577	1,430	2,743	2,133
84	2,719	2,958	3,686	1,474	2,827	2,197
85	2,813	3,061	3,813	1,526	2,925	2,274
86	2,894	3,149	3,924	1,569	3,009	2,340
87	2,975	3,239	4,035	1,614	3,094	2,406
88	3,061	3,330	4,148	1,659	3,180	2,473
89	3,145	3,421	4,263	1,704	3,269	2,541
90	3,232	3,515	4,379	1,753	3,359	2,612
91	3,320	3,610	4,499	1,799	3,450	2,682
92	3,410	3,709	4,620	1,849	3,543	2,755
93	3,500	3,808	4,743	1,898	3,637	2,828
94	3,592	3,907	4,869	1,948	3,734	2,903
95	3,686	4,010	4,996	1,998	3,831	2,980
96	3,781	4,113	5,126	2,050	3,930	3,056
97	3,878	4,218	5,257	2,103	4,031	3,133
98	3,977	4,324	5,389	2,156	4,133	3,213
99+	4,076	4,432	5,524	2,210	4,236	3,293

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 a 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 and Life Insurance Company

Annual Premiums

For Use in: Rest of State

Male Rates

Rates Effective 8/1/2019

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,696	1,844	2,297	920	1,762	1,184
66	1,696	1,844	2,297	920	1,762	1,222
67	1,696	1,844	2,297	920	1,762	1,259
68	1,716	1,866	2,325	930	1,784	1,311
69	1,753	1,905	2,375	950	1,821	1,378
70	1,798	1,956	2,436	975	1,869	1,453
71	1,853	2,015	2,512	1,004	1,926	1,498
72	1,911	2,078	2,590	1,036	1,986	1,545
73	1,973	2,146	2,674	1,069	2,051	1,594
74	2,042	2,220	2,767	1,107	2,123	1,651
75	2,116	2,303	2,870	1,148	2,200	1,711
76	2,191	2,382	2,970	1,188	2,277	1,770
77	2,264	2,463	3,069	1,227	2,353	1,831
78	2,338	2,543	3,170	1,268	2,431	1,890
79	2,416	2,627	3,273	1,310	2,510	1,951
80	2,492	2,709	3,376	1,350	2,589	2,012
81	2,569	2,794	3,483	1,392	2,670	2,076
82	2,649	2,883	3,590	1,435	2,753	2,141
83	2,730	2,971	3,702	1,480	2,839	2,208
84	2,814	3,062	3,815	1,526	2,925	2,274
85	2,912	3,168	3,947	1,580	3,027	2,354
86	2,996	3,259	4,061	1,625	3,114	2,421
87	3,080	3,352	4,175	1,671	3,203	2,490
88	3,168	3,445	4,293	1,718	3,292	2,559
89	3,255	3,540	4,412	1,765	3,383	2,629
90	3,346	3,639	4,533	1,814	3,477	2,703
91	3,437	3,738	4,657	1,862	3,571	2,776
92	3,529	3,837	4,782	1,913	3,668	2,851
93	3,623	3,941	4,911	1,965	3,765	2,927
94	3,718	4,044	5,039	2,016	3,864	3,005
95	3,815	4,149	5,171	2,068	3,966	3,084
96	3,914	4,257	5,305	2,122	4,068	3,162
97	4,014	4,366	5,441	2,176	4,172	3,244
98	4,115	4,476	5,578	2,231	4,277	3,325
99+	4,218	4,588	5,718	2,287	4,385	3,408

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,884	2,049	2,554	1,021	1,957	1,316
66	1,884	2,049	2,554	1,021	1,957	1,358
67	1,884	2,049	2,554	1,021	1,957	1,399
68	1,906	2,074	2,583	1,034	1,981	1,456
69	1,947	2,116	2,637	1,057	2,023	1,532
70	1,998	2,174	2,709	1,084	2,077	1,615
71	2,060	2,240	2,791	1,116	2,140	1,665
72	2,123	2,309	2,878	1,150	2,206	1,716
73	2,192	2,384	2,971	1,188	2,279	1,771
74	2,269	2,468	3,076	1,229	2,358	1,834
75	2,351	2,557	3,188	1,275	2,444	1,901
76	2,434	2,648	3,300	1,320	2,531	1,968
77	2,515	2,738	3,411	1,364	2,616	2,033
78	2,598	2,826	3,521	1,408	2,702	2,100
79	2,684	2,919	3,636	1,455	2,788	2,169
80	2,767	3,010	3,752	1,500	2,876	2,236
81	2,854	3,105	3,870	1,548	2,967	2,307
82	2,944	3,202	3,990	1,594	3,059	2,379
83	3,035	3,302	4,113	1,645	3,154	2,453
84	3,128	3,402	4,239	1,696	3,251	2,527
85	3,236	3,520	4,385	1,755	3,364	2,615
86	3,329	3,622	4,512	1,806	3,461	2,690
87	3,423	3,724	4,641	1,855	3,558	2,767
88	3,520	3,829	4,770	1,907	3,657	2,844
89	3,616	3,936	4,902	1,959	3,759	2,922
90	3,717	4,042	5,036	2,016	3,863	3,004
91	3,818	4,153	5,174	2,069	3,968	3,084
92	3,921	4,265	5,313	2,127	4,074	3,168
93	4,026	4,379	5,455	2,182	4,183	3,252
94	4,131	4,494	5,599	2,241	4,293	3,339
95	4,239	4,611	5,746	2,297	4,406	3,426
96	4,348	4,730	5,895	2,358	4,519	3,514
97	4,460	4,851	6,046	2,418	4,636	3,604
98	4,574	4,972	6,197	2,479	4,752	3,695
99+	4,687	5,098	6,353	2,541	4,871	3,787

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 a 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 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 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 American Continental 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 $1,364	$0	$1,364 (Part A Deductible)
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	$0	Up to $170.50 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 $185 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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (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 $1,364	$1,364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	$0	Up to $170.50 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 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 $185 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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (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 $1,364	$1,364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 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 $185 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 $185 of Medicare-Approved amounts*	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$185 (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 $ 2,300 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses are $2,300 . 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 $2,300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,300 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 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 $185 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 $2,300 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses are $2,300 . 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 $2,300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,300 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 $185 of Medicare-Approved amounts*	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$185 (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 $2,300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,300 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $185 of Medicare Approved amounts*	$0	$185 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN F OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,300 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,300 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 $1,364	$1,364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 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 $185 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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (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 $1,364	$1,364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 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 $185 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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (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