Outline of coverage

Medicare Supplement Insurance

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

Kansas

Underwritten by

Aetna Health Insurance Company

AetnaSeniorProducts.com

AHCMS04870KS

Rates effective: 03/2024 A

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and High Deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 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 Insurance Company
Annual premiums
For use in ZIP Codes: 661-662, 672
Female rates
Rates effective 03/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,731	2,004	2,200	1,959	588	1,310
65	1,731	2,004	2,200	1,959	588	1,310
66	1,731	2,004	2,200	1,959	588	1,310
67	1,731	2,004	2,200	1,959	588	1,310
68	1,751	2,026	2,223	1,981	593	1,358
69	1,790	2,074	2,276	2,026	607	1,413
70	1,837	2,129	2,337	2,079	623	1,468
71	1,891	2,192	2,406	2,141	642	1,520
72	1,950	2,260	2,482	2,209	662	1,571
73	2,014	2,333	2,562	2,281	684	1,624
74	2,085	2,416	2,650	2,362	707	1,678
75	2,159	2,499	2,744	2,443	732	1,731
76	2,232	2,589	2,839	2,529	758	1,788
77	2,312	2,679	2,942	2,616	784	1,848
78	2,392	2,770	3,041	2,706	811	1,911
79	2,466	2,858	3,136	2,791	837	1,971
80	2,544	2,947	3,235	2,878	863	2,038
81	2,623	3,040	3,336	2,969	890	2,102
82	2,701	3,131	3,435	3,056	917	2,163
83	2,786	3,226	3,541	3,151	945	2,231
84	2,866	3,321	3,645	3,243	972	2,296
85	2,970	3,441	3,777	3,362	1,008	2,378
86	3,055	3,540	3,884	3,459	1,037	2,446
87	3,141	3,640	3,995	3,556	1,066	2,516
88	3,231	3,742	4,106	3,656	1,096	2,587
89	3,321	3,846	4,222	3,757	1,126	2,658
90	3,412	3,952	4,337	3,862	1,158	2,732
91	3,505	4,060	4,456	3,967	1,189	2,807
92	3,600	4,170	4,575	4,074	1,220	2,883
93	3,696	4,281	4,699	4,181	1,253	2,959
94	3,793	4,393	4,822	4,291	1,286	3,037
95	3,891	4,507	4,949	4,404	1,320	3,116
96	3,994	4,623	5,075	4,518	1,354	3,196
97	4,093	4,742	5,205	4,633	1,389	3,278
98	4,197	4,861	5,335	4,749	1,423	3,362
99+	4,302	4,984	5,469	4,870	1,459	3,444

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,925	2,228	2,446	2,176	652	1,456
65	1,925	2,228	2,446	2,176	652	1,456
66	1,925	2,228	2,446	2,176	652	1,456
67	1,925	2,228	2,446	2,176	652	1,456
68	1,945	2,253	2,471	2,199	659	1,509
69	1,987	2,304	2,527	2,252	674	1,570
70	2,041	2,364	2,596	2,311	692	1,630
71	2,102	2,435	2,673	2,379	713	1,688
72	2,169	2,513	2,757	2,455	735	1,745
73	2,238	2,592	2,846	2,534	759	1,804
74	2,318	2,685	2,945	2,624	786	1,865
75	2,399	2,778	3,050	2,715	813	1,925
76	2,481	2,876	3,155	2,808	842	1,987
77	2,570	2,976	3,267	2,910	872	2,053
78	2,657	3,078	3,378	3,007	901	2,121
79	2,742	3,174	3,484	3,101	930	2,189
80	2,825	3,276	3,594	3,199	959	2,264
81	2,915	3,377	3,705	3,298	989	2,335
82	3,002	3,478	3,817	3,398	1,018	2,403
83	3,093	3,585	3,934	3,504	1,050	2,479
84	3,185	3,689	4,050	3,603	1,080	2,551
85	3,303	3,824	4,196	3,737	1,120	2,644
86	3,397	3,932	4,317	3,844	1,152	2,718
87	3,492	4,044	4,439	3,951	1,185	2,795
88	3,588	4,158	4,562	4,061	1,218	2,875
89	3,689	4,272	4,690	4,176	1,252	2,954
90	3,792	4,390	4,821	4,289	1,286	3,036
91	3,893	4,512	4,952	4,406	1,321	3,119
92	3,999	4,632	5,084	4,526	1,356	3,200
93	4,105	4,756	5,219	4,646	1,392	3,289
94	4,214	4,881	5,357	4,768	1,429	3,375
95	4,325	5,009	5,496	4,892	1,467	3,461
96	4,436	5,139	5,638	5,018	1,504	3,552
97	4,548	5,270	5,783	5,147	1,543	3,642
98	4,663	5,400	5,930	5,277	1,581	3,737
99+	4,780	5,537	6,075	5,410	1,621	3,828

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

To calculate the 7% household discount:

Annual premium **x** modal factor **= modal premium** (round to nearest whole cent)
Modal premium **x** .93 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

Aetna Health Insurance Company
Annual premiums
For use in ZIP Codes: 661-662, 672
Male rates

Rates effective 03/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,990	2,305	2,533	2,253	676	1,508
65	1,990	2,305	2,533	2,253	676	1,508
66	1,990	2,305	2,533	2,253	676	1,508
67	1,990	2,305	2,533	2,253	676	1,508
68	2,012	2,330	2,559	2,278	681	1,560
69	2,057	2,385	2,616	2,328	698	1,625
70	2,114	2,446	2,687	2,392	717	1,687
71	2,175	2,521	2,767	2,463	738	1,746
72	2,244	2,600	2,851	2,539	761	1,808
73	2,317	2,685	2,944	2,623	786	1,866
74	2,399	2,779	3,049	2,715	813	1,929
75	2,481	2,875	3,157	2,808	842	1,992
76	2,569	2,978	3,266	2,910	872	2,056
77	2,661	3,080	3,383	3,010	902	2,125
78	2,749	3,185	3,497	3,111	933	2,197
79	2,837	3,283	3,607	3,210	962	2,267
80	2,926	3,389	3,720	3,311	993	2,341
81	3,016	3,495	3,834	3,414	1,024	2,418
82	3,107	3,600	3,951	3,516	1,054	2,487
83	3,203	3,710	4,073	3,623	1,086	2,566
84	3,297	3,817	4,193	3,729	1,118	2,641
85	3,416	3,957	4,343	3,867	1,159	2,736
86	3,514	4,072	4,468	3,977	1,192	2,814
87	3,613	4,186	4,595	4,090	1,226	2,894
88	3,715	4,303	4,723	4,204	1,260	2,974
89	3,817	4,422	4,856	4,322	1,295	3,055
90	3,924	4,545	4,989	4,441	1,332	3,141
91	4,031	4,668	5,125	4,560	1,367	3,227
92	4,139	4,795	5,262	4,685	1,404	3,315
93	4,250	4,922	5,402	4,807	1,441	3,404
94	4,361	5,051	5,544	4,937	1,480	3,494
95	4,476	5,184	5,687	5,064	1,517	3,582
96	4,592	5,318	5,836	5,198	1,557	3,677
97	4,707	5,454	5,985	5,329	1,597	3,769
98	4,825	5,588	6,138	5,463	1,637	3,867
99+	4,946	5,729	6,288	5,598	1,678	3,960

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	2,212	2,561	2,813	2,503	751	1,674
65	2,212	2,561	2,813	2,503	751	1,674
66	2,212	2,561	2,813	2,503	751	1,674
67	2,212	2,561	2,813	2,503	751	1,674
68	2,236	2,590	2,844	2,529	758	1,736
69	2,287	2,649	2,908	2,590	775	1,805
70	2,348	2,719	2,986	2,657	796	1,875
71	2,418	2,803	3,074	2,736	820	1,941
72	2,493	2,889	3,171	2,823	846	2,008
73	2,574	2,981	3,271	2,913	873	2,074
74	2,664	3,088	3,388	3,016	904	2,145
75	2,758	3,195	3,507	3,122	935	2,213
76	2,853	3,309	3,630	3,230	969	2,287
77	2,955	3,423	3,757	3,346	1,002	2,361
78	3,054	3,540	3,886	3,459	1,036	2,440
79	3,151	3,650	4,007	3,565	1,069	2,517
80	3,251	3,766	4,132	3,681	1,103	2,603
81	3,352	3,885	4,261	3,793	1,137	2,686
82	3,452	3,999	4,388	3,906	1,171	2,766
83	3,560	4,121	4,525	4,027	1,207	2,850
84	3,666	4,243	4,656	4,145	1,242	2,933
85	3,797	4,397	4,825	4,298	1,288	3,040
86	3,905	4,522	4,965	4,418	1,325	3,126
87	4,015	4,652	5,106	4,545	1,363	3,217
88	4,127	4,782	5,249	4,670	1,401	3,305
89	4,243	4,913	5,395	4,801	1,440	3,397
90	4,360	5,049	5,543	4,933	1,480	3,493
91	4,477	5,188	5,694	5,068	1,518	3,586
92	4,598	5,329	5,845	5,203	1,560	3,683
93	4,721	5,469	6,003	5,343	1,601	3,780
94	4,846	5,614	6,160	5,485	1,643	3,883
95	4,974	5,760	6,320	5,628	1,687	3,981
96	5,103	5,909	6,484	5,773	1,730	4,086
97	5,227	6,060	6,651	5,921	1,774	4,188
98	5,362	6,211	6,819	6,067	1,819	4,296
99+	5,496	6,368	6,989	6,221	1,864	4,403

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

To calculate the 7% household discount:

Annual premium **x** modal factor **= modal premium** (round to nearest whole cent)
Modal premium **x** .93 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

Aetna Health Insurance Company
Annual premiums
For use in: Rest of State
Female rates
Rates effective 03/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,603	1,856	2,037	1,814	544	1,213
65	1,603	1,856	2,037	1,814	544	1,213
66	1,603	1,856	2,037	1,814	544	1,213
67	1,603	1,856	2,037	1,814	544	1,213
68	1,621	1,876	2,058	1,834	549	1,257
69	1,657	1,920	2,107	1,876	562	1,308
70	1,701	1,971	2,164	1,925	577	1,359
71	1,751	2,030	2,228	1,982	594	1,407
72	1,806	2,093	2,298	2,045	613	1,455
73	1,865	2,160	2,372	2,112	633	1,504
74	1,931	2,237	2,454	2,187	655	1,554
75	1,999	2,314	2,541	2,262	678	1,603
76	2,067	2,397	2,629	2,342	702	1,656
77	2,141	2,481	2,724	2,422	726	1,711
78	2,215	2,565	2,816	2,506	751	1,769
79	2,283	2,646	2,904	2,584	775	1,825
80	2,356	2,729	2,995	2,665	799	1,887
81	2,429	2,815	3,089	2,749	824	1,946
82	2,501	2,899	3,181	2,830	849	2,003
83	2,580	2,987	3,279	2,918	875	2,066
84	2,654	3,075	3,375	3,003	900	2,126
85	2,750	3,186	3,497	3,113	933	2,202
86	2,829	3,278	3,596	3,203	960	2,265
87	2,908	3,370	3,699	3,293	987	2,330
88	2,992	3,465	3,802	3,385	1,015	2,395
89	3,075	3,561	3,909	3,479	1,043	2,461
90	3,159	3,659	4,016	3,576	1,072	2,530
91	3,245	3,759	4,126	3,673	1,101	2,599
92	3,333	3,861	4,236	3,772	1,130	2,669
93	3,422	3,964	4,351	3,871	1,160	2,740
94	3,512	4,068	4,465	3,973	1,191	2,812
95	3,603	4,173	4,582	4,078	1,222	2,885
96	3,698	4,281	4,699	4,183	1,254	2,959
97	3,790	4,391	4,819	4,290	1,286	3,035
98	3,886	4,501	4,940	4,397	1,318	3,113
99+	3,983	4,615	5,064	4,509	1,351	3,189

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,782	2,063	2,265	2,015	604	1,348
65	1,782	2,063	2,265	2,015	604	1,348
66	1,782	2,063	2,265	2,015	604	1,348
67	1,782	2,063	2,265	2,015	604	1,348
68	1,801	2,086	2,288	2,036	610	1,397
69	1,840	2,133	2,340	2,085	624	1,454
70	1,890	2,189	2,404	2,140	641	1,509
71	1,946	2,255	2,475	2,203	660	1,563
72	2,008	2,327	2,553	2,273	681	1,616
73	2,072	2,400	2,635	2,346	703	1,670
74	2,146	2,486	2,727	2,430	728	1,727
75	2,221	2,572	2,824	2,514	753	1,782
76	2,297	2,663	2,921	2,600	780	1,840
77	2,380	2,756	3,025	2,694	807	1,901
78	2,460	2,850	3,128	2,784	834	1,964
79	2,539	2,939	3,226	2,871	861	2,027
80	2,616	3,033	3,328	2,962	888	2,096
81	2,699	3,127	3,431	3,054	916	2,162
82	2,780	3,220	3,534	3,146	943	2,225
83	2,864	3,319	3,643	3,244	972	2,295
84	2,949	3,416	3,750	3,336	1,000	2,362
85	3,058	3,541	3,885	3,460	1,037	2,448
86	3,145	3,641	3,997	3,559	1,067	2,517
87	3,233	3,744	4,110	3,658	1,097	2,588
88	3,322	3,850	4,224	3,760	1,128	2,662
89	3,416	3,956	4,343	3,867	1,159	2,735
90	3,511	4,065	4,464	3,971	1,191	2,811
91	3,605	4,178	4,585	4,080	1,223	2,888
92	3,703	4,289	4,707	4,191	1,256	2,963
93	3,801	4,404	4,832	4,302	1,289	3,045
94	3,902	4,519	4,960	4,415	1,323	3,125
95	4,005	4,638	5,089	4,530	1,358	3,205
96	4,107	4,758	5,220	4,646	1,393	3,289
97	4,211	4,880	5,355	4,766	1,429	3,372
98	4,318	5,000	5,491	4,886	1,464	3,460
99+	4,426	5,127	5,625	5,009	1,501	3,544

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

To calculate the 7% household discount:

Annual premium **x** modal factor **= modal premium** (round to nearest whole cent)
Modal premium **x** .93 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

Aetna Health Insurance Company
Annual premiums
For use in: Rest of State
Male rates

Rates effective 03/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,843	2,134	2,345	2,086	626	1,396
65	1,843	2,134	2,345	2,086	626	1,396
66	1,843	2,134	2,345	2,086	626	1,396
67	1,843	2,134	2,345	2,086	626	1,396
68	1,863	2,157	2,369	2,109	631	1,444
69	1,905	2,208	2,422	2,156	646	1,505
70	1,957	2,265	2,488	2,215	664	1,562
71	2,014	2,334	2,562	2,281	683	1,617
72	2,078	2,407	2,640	2,351	705	1,674
73	2,145	2,486	2,726	2,429	728	1,728
74	2,221	2,573	2,823	2,514	753	1,786
75	2,297	2,662	2,923	2,600	780	1,844
76	2,379	2,757	3,024	2,694	807	1,904
77	2,464	2,852	3,132	2,787	835	1,968
78	2,545	2,949	3,238	2,881	864	2,034
79	2,627	3,040	3,340	2,972	891	2,099
80	2,709	3,138	3,444	3,066	919	2,168
81	2,793	3,236	3,550	3,161	948	2,239
82	2,877	3,333	3,658	3,256	976	2,303
83	2,966	3,435	3,771	3,355	1,006	2,376
84	3,053	3,534	3,882	3,453	1,035	2,445
85	3,163	3,664	4,021	3,581	1,073	2,533
86	3,254	3,770	4,137	3,682	1,104	2,606
87	3,345	3,876	4,255	3,787	1,135	2,680
88	3,440	3,984	4,373	3,893	1,167	2,754
89	3,534	4,094	4,496	4,002	1,199	2,829
90	3,633	4,208	4,619	4,112	1,233	2,908
91	3,732	4,322	4,745	4,222	1,266	2,988
92	3,832	4,440	4,872	4,338	1,300	3,069
93	3,935	4,557	5,002	4,451	1,334	3,152
94	4,038	4,677	5,133	4,571	1,370	3,235
95	4,144	4,800	5,266	4,689	1,405	3,317
96	4,252	4,924	5,404	4,813	1,442	3,405
97	4,358	5,050	5,542	4,934	1,479	3,490
98	4,468	5,174	5,683	5,058	1,516	3,581
99+	4,580	5,305	5,822	5,183	1,554	3,667

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	2,048	2,371	2,605	2,318	695	1,550
65	2,048	2,371	2,605	2,318	695	1,550
66	2,048	2,371	2,605	2,318	695	1,550
67	2,048	2,371	2,605	2,318	695	1,550
68	2,070	2,398	2,633	2,342	702	1,607
69	2,118	2,453	2,693	2,398	718	1,671
70	2,174	2,518	2,765	2,460	737	1,736
71	2,239	2,595	2,846	2,533	759	1,797
72	2,308	2,675	2,936	2,614	783	1,859
73	2,383	2,760	3,029	2,697	808	1,920
74	2,467	2,859	3,137	2,793	837	1,986
75	2,554	2,958	3,247	2,891	866	2,049
76	2,642	3,064	3,361	2,991	897	2,118
77	2,736	3,169	3,479	3,098	928	2,186
78	2,828	3,278	3,598	3,203	959	2,259
79	2,918	3,380	3,710	3,301	990	2,331
80	3,010	3,487	3,826	3,408	1,021	2,410
81	3,104	3,597	3,945	3,512	1,053	2,487
82	3,196	3,703	4,063	3,617	1,084	2,561
83	3,296	3,816	4,190	3,729	1,118	2,639
84	3,394	3,929	4,311	3,838	1,150	2,716
85	3,516	4,071	4,468	3,980	1,193	2,815
86	3,616	4,187	4,597	4,091	1,227	2,894
87	3,718	4,307	4,728	4,208	1,262	2,979
88	3,821	4,428	4,860	4,324	1,297	3,060
89	3,929	4,549	4,995	4,445	1,333	3,145
90	4,037	4,675	5,132	4,568	1,370	3,234
91	4,145	4,804	5,272	4,693	1,406	3,320
92	4,257	4,934	5,412	4,818	1,444	3,410
93	4,371	5,064	5,558	4,947	1,482	3,500
94	4,487	5,198	5,704	5,079	1,521	3,595
95	4,606	5,333	5,852	5,211	1,562	3,686
96	4,725	5,471	6,004	5,345	1,602	3,783
97	4,840	5,611	6,158	5,482	1,643	3,878
98	4,965	5,751	6,314	5,618	1,684	3,978
99+	5,089	5,896	6,471	5,760	1,726	4,077

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

To calculate the 7% household discount:

Annual premium **x** modal factor **= modal premium** (round to nearest whole cent)
Modal premium **x** .93 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

PREMIUM INFORMATION

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

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

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

HOUSEHOLD DISCOUNT

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

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

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

YOU HAVE PURCHASED PLAN _____

PREMIUM FOR THIS PLAN IS $

PREMIUM WILL BE PAID _____

AGENT'S NAME: _____

AGENT'S ADDRESS: _____

SIGNATURE/DATE: _____

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Aetna Health Insurance Company, P.O. Box 14770, Lexington, Kentucky 40512-4770. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

POLICY REPLACEMENT

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

NOTICE

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$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

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

HIGH DEDUCTIBLE PLAN G

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

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

****This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,800 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 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 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.

****This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,800 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 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	$0	$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 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	$0	$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 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 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