Outline of coverage

Medicare Supplement Insurance

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

Kentucky

Underwritten by

Aetna Health and Life Insurance Company

AetnaSeniorProducts.com

AHLMS05546KY

Rates effective: 01/2024 A

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

This chart shows the benefits included in each of the standard Medicare supplement plans.
Every Company must make Plan "A and either Plan C or F available for those eligible for Medicare prior to January 1, 2020 and either Plan D or G available for those eligible for Medicare on or after January 1 2020."Every company must make Plan "A" available. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible

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

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2024[2]					**$7,060[2]**	**$3,530[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,800** before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

Aetna Health and Life Insurance Company

Annual Attained Age Premiums

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

Female Rates

Rates effective 1/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,332	2,734	3,662	898	2,481	1,489
65	1,981	2,246	2,968	729	1,998	1,191
66	2,037	2,320	3,073	753	2,069	1,235
67	2,092	2,392	3,167	777	2,133	1,275
68	2,146	2,460	3,268	803	2,201	1,316
69	2,201	2,532	3,361	827	2,268	1,359
70	2,253	2,599	3,459	849	2,337	1,397
71	2,307	2,670	3,554	872	2,399	1,438
72	2,359	2,735	3,648	895	2,464	1,477
73	2,401	2,804	3,747	920	2,535	1,519
74	2,448	2,872	3,842	944	2,605	1,562
75	2,491	2,938	3,941	967	2,673	1,605
76	2,533	3,007	4,034	991	2,735	1,647
77	2,576	3,075	4,131	1,015	2,803	1,688
78	2,606	3,134	4,225	1,037	2,870	1,733
79	2,632	3,194	4,318	1,060	2,941	1,774
80	2,660	3,255	4,411	1,083	3,007	1,818
81	2,689	3,318	4,502	1,105	3,074	1,862
82	2,714	3,375	4,595	1,128	3,140	1,903
83	2,747	3,430	4,687	1,151	3,210	1,950
84	2,784	3,485	4,779	1,172	3,276	1,995
85	2,809	3,526	4,853	1,191	3,337	2,036
86	2,839	3,571	4,934	1,212	3,398	2,076
87	2,865	3,617	5,012	1,232	3,459	2,119
88	2,891	3,664	5,098	1,251	3,524	2,163
89	2,920	3,709	5,176	1,271	3,586	2,205
90	2,947	3,751	5,257	1,290	3,651	2,245
91	2,977	3,797	5,335	1,310	3,711	2,289
92	3,004	3,840	5,417	1,329	3,774	2,329
93	3,036	3,882	5,491	1,349	3,832	2,368
94	3,062	3,922	5,565	1,366	3,895	2,412
95	3,094	3,962	5,642	1,385	3,950	2,448
96	3,122	4,001	5,713	1,403	4,007	2,489
97	3,153	4,042	5,786	1,421	4,064	2,527
98	3,187	4,081	5,859	1,438	4,118	2,565
99+	3,213	4,120	5,932	1,456	4,173	2,601

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,591	3,037	4,069	998	2,757	2,757
65	2,201	2,496	3,301	810	2,221	1,325
66	2,266	2,575	3,413	837	2,297	1,371
67	2,325	2,655	3,522	865	2,370	1,417
68	2,384	2,732	3,629	891	2,447	1,463
69	2,447	2,811	3,738	919	2,520	1,508
70	2,505	2,889	3,842	944	2,593	1,551
71	2,566	2,965	3,947	969	2,666	1,597
72	2,622	3,041	4,053	996	2,740	1,639
73	2,671	3,117	4,162	1,022	2,814	1,688
74	2,721	3,191	4,271	1,050	2,893	1,737
75	2,767	3,267	4,376	1,074	2,966	1,783
76	2,819	3,340	4,482	1,102	3,042	1,830
77	2,865	3,413	4,585	1,127	3,115	1,877
78	2,895	3,482	4,694	1,152	3,190	1,925
79	2,927	3,550	4,800	1,179	3,267	1,972
80	2,956	3,617	4,901	1,204	3,341	2,019
81	2,985	3,687	5,006	1,227	3,416	2,068
82	3,018	3,751	5,107	1,254	3,490	2,116
83	3,054	3,813	5,206	1,279	3,566	2,165
84	3,094	3,872	5,307	1,302	3,640	2,216
85	3,122	3,918	5,394	1,324	3,709	2,261
86	3,153	3,968	5,480	1,348	3,777	2,307
87	3,181	4,019	5,572	1,367	3,846	2,355
88	3,213	4,071	5,665	1,389	3,918	2,402
89	3,246	4,120	5,753	1,412	3,986	2,450
90	3,275	4,169	5,842	1,434	4,054	2,496
91	3,306	4,221	5,929	1,457	4,125	2,542
92	3,338	4,265	6,017	1,478	4,194	2,589
93	3,372	4,313	6,100	1,498	4,260	2,635
94	3,402	4,357	6,185	1,517	4,323	2,678
95	3,436	4,402	6,266	1,539	4,388	2,721
96	3,470	4,446	6,348	1,558	4,452	2,765
97	3,504	4,494	6,431	1,579	4,515	2,808
98	3,539	4,537	6,508	1,597	4,578	2,851
99+	3,570	4,579	6,590	1,618	4,639	2,891

To calculate a household discount:

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

Modal premium **x** discount (.93)**= discounted premium**

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

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly.....0.0833

Aetna Health and Life Insurance Company

Annual Attained Age Premiums

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

Male Rates

Rates effective 1/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,683	3,144	4,211	1,034	2,852	1,714
65	2,280	2,585	3,416	838	2,299	1,371
66	2,341	2,662	3,533	867	2,376	1,419
67	2,409	2,746	3,644	894	2,455	1,467
68	2,469	2,828	3,757	922	2,533	1,515
69	2,532	2,911	3,870	951	2,608	1,561
70	2,591	2,992	3,978	976	2,685	1,608
71	2,655	3,069	4,089	1,003	2,760	1,654
72	2,714	3,149	4,195	1,029	2,832	1,699
73	2,766	3,228	4,308	1,058	2,913	1,748
74	2,819	3,305	4,421	1,086	2,996	1,796
75	2,865	3,382	4,529	1,112	3,072	1,846
76	2,914	3,460	4,640	1,140	3,145	1,894
77	2,965	3,534	4,748	1,167	3,223	1,941
78	2,996	3,604	4,859	1,193	3,299	1,993
79	3,031	3,675	4,969	1,220	3,382	2,042
80	3,058	3,746	5,072	1,245	3,458	2,092
81	3,092	3,815	5,182	1,271	3,537	2,142
82	3,121	3,882	5,284	1,297	3,612	2,190
83	3,160	3,946	5,390	1,324	3,690	2,241
84	3,203	4,008	5,496	1,349	3,770	2,294
85	3,232	4,055	5,581	1,371	3,839	2,340
86	3,265	4,108	5,674	1,394	3,905	2,390
87	3,295	4,162	5,765	1,416	3,982	2,437
88	3,325	4,210	5,862	1,439	4,054	2,487
89	3,357	4,265	5,951	1,462	4,126	2,536
90	3,390	4,314	6,046	1,484	4,198	2,584
91	3,425	4,368	6,133	1,507	4,268	2,631
92	3,456	4,416	6,226	1,528	4,340	2,680
93	3,488	4,462	6,315	1,550	4,405	2,726
94	3,524	4,508	6,401	1,571	4,474	2,770
95	3,556	4,556	6,487	1,593	4,540	2,816
96	3,591	4,605	6,571	1,613	4,609	2,861
97	3,627	4,651	6,656	1,634	4,675	2,906
98	3,660	4,693	6,738	1,653	4,736	2,949
99+	3,694	4,738	6,820	1,673	4,801	2,993

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,981	3,494	4,679	1,149	3,169	3,169
65	2,532	2,870	3,797	932	2,553	1,523
66	2,606	2,964	3,925	964	2,640	1,577
67	2,675	3,054	4,050	995	2,729	1,630
68	2,746	3,143	4,178	1,026	2,813	1,685
69	2,818	3,233	4,301	1,056	2,899	1,734
70	2,882	3,325	4,421	1,086	2,983	1,785
71	2,949	3,411	4,543	1,116	3,067	1,837
72	3,018	3,498	4,662	1,144	3,151	1,885
73	3,075	3,585	4,786	1,174	3,237	1,941
74	3,129	3,671	4,912	1,206	3,327	1,996
75	3,187	3,758	5,032	1,235	3,411	2,053
76	3,240	3,841	5,154	1,266	3,495	2,105
77	3,295	3,927	5,275	1,296	3,582	2,156
78	3,326	4,007	5,400	1,325	3,666	2,214
79	3,365	4,081	5,520	1,355	3,758	2,268
80	3,399	4,162	5,636	1,385	3,843	2,323
81	3,435	4,239	5,756	1,412	3,928	2,377
82	3,470	4,314	5,872	1,441	4,010	2,433
83	3,516	4,384	5,987	1,471	4,101	2,490
84	3,556	4,455	6,104	1,496	4,188	2,548
85	3,591	4,505	6,203	1,523	4,265	2,599
86	3,627	4,563	6,305	1,548	4,342	2,653
87	3,659	4,624	6,403	1,573	4,424	2,708
88	3,694	4,679	6,516	1,599	4,503	2,763
89	3,732	4,738	6,613	1,624	4,586	2,818
90	3,765	4,794	6,716	1,649	4,662	2,870
91	3,804	4,853	6,818	1,676	4,744	2,924
92	3,840	4,904	6,920	1,699	4,821	2,977
93	3,877	4,962	7,017	1,724	4,897	3,028
94	3,913	5,011	7,112	1,746	4,971	3,080
95	3,953	5,066	7,209	1,770	5,046	3,129
96	3,989	5,115	7,300	1,792	5,120	3,177
97	4,033	5,166	7,396	1,816	5,193	3,229
98	4,071	5,215	7,484	1,837	5,264	3,278
99+	4,106	5,267	7,580	1,860	5,334	3,325

To calculate a household discount:

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

Modal premium **x** discount (.93)**= discounted premium**

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

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly.....0.0833

Aetna Health and Life Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of State

Female Rates

Rates effective 1/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,028	2,377	3,184	781	2,157	1,295
65	1,723	1,953	2,581	634	1,737	1,036
66	1,771	2,017	2,672	655	1,799	1,074
67	1,819	2,080	2,754	676	1,855	1,109
68	1,866	2,139	2,842	698	1,914	1,144
69	1,914	2,202	2,923	719	1,972	1,182
70	1,959	2,260	3,008	738	2,032	1,215
71	2,006	2,322	3,090	758	2,086	1,250
72	2,051	2,378	3,172	778	2,143	1,284
73	2,088	2,438	3,258	800	2,204	1,321
74	2,129	2,497	3,341	821	2,265	1,358
75	2,166	2,555	3,427	841	2,324	1,396
76	2,203	2,615	3,508	862	2,378	1,432
77	2,240	2,674	3,592	883	2,437	1,468
78	2,266	2,725	3,674	902	2,496	1,507
79	2,289	2,777	3,755	922	2,557	1,543
80	2,313	2,830	3,836	942	2,615	1,581
81	2,338	2,885	3,915	961	2,673	1,619
82	2,360	2,935	3,996	981	2,730	1,655
83	2,389	2,983	4,076	1,001	2,791	1,696
84	2,421	3,030	4,156	1,019	2,849	1,735
85	2,443	3,066	4,220	1,036	2,902	1,770
86	2,469	3,105	4,290	1,054	2,955	1,805
87	2,491	3,145	4,358	1,071	3,008	1,843
88	2,514	3,186	4,433	1,088	3,064	1,881
89	2,539	3,225	4,501	1,105	3,118	1,917
90	2,563	3,262	4,571	1,122	3,175	1,952
91	2,589	3,302	4,639	1,139	3,227	1,990
92	2,612	3,339	4,710	1,156	3,282	2,025
93	2,640	3,376	4,775	1,173	3,332	2,059
94	2,663	3,410	4,839	1,188	3,387	2,097
95	2,690	3,445	4,906	1,204	3,435	2,129
96	2,715	3,479	4,968	1,220	3,484	2,164
97	2,742	3,515	5,031	1,236	3,534	2,197
98	2,771	3,549	5,095	1,250	3,581	2,230
99+	2,794	3,583	5,158	1,266	3,629	2,262

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,253	2,641	3,538	868	2,397	2,397
65	1,914	2,170	2,870	704	1,931	1,152
66	1,970	2,239	2,968	728	1,997	1,192
67	2,022	2,309	3,063	752	2,061	1,232
68	2,073	2,376	3,156	775	2,128	1,272
69	2,128	2,444	3,250	799	2,191	1,311
70	2,178	2,512	3,341	821	2,255	1,349
71	2,231	2,578	3,432	843	2,318	1,389
72	2,280	2,644	3,524	866	2,383	1,425
73	2,323	2,710	3,619	889	2,447	1,468
74	2,366	2,775	3,714	913	2,516	1,510
75	2,406	2,841	3,805	934	2,579	1,550
76	2,451	2,904	3,897	958	2,645	1,591
77	2,491	2,968	3,987	980	2,709	1,632
78	2,517	3,028	4,082	1,002	2,774	1,674
79	2,545	3,087	4,174	1,025	2,841	1,715
80	2,570	3,145	4,262	1,047	2,905	1,756
81	2,596	3,206	4,353	1,067	2,970	1,798
82	2,624	3,262	4,441	1,090	3,035	1,840
83	2,656	3,316	4,527	1,112	3,101	1,883
84	2,690	3,367	4,615	1,132	3,165	1,927
85	2,715	3,407	4,690	1,151	3,225	1,966
86	2,742	3,450	4,765	1,172	3,284	2,006
87	2,766	3,495	4,845	1,189	3,344	2,048
88	2,794	3,540	4,926	1,208	3,407	2,089
89	2,823	3,583	5,003	1,228	3,466	2,130
90	2,848	3,625	5,080	1,247	3,525	2,170
91	2,875	3,670	5,156	1,267	3,587	2,210
92	2,903	3,709	5,232	1,285	3,647	2,251
93	2,932	3,750	5,304	1,303	3,704	2,291
94	2,958	3,789	5,378	1,319	3,759	2,329
95	2,988	3,828	5,449	1,338	3,816	2,366
96	3,017	3,866	5,520	1,355	3,871	2,404
97	3,047	3,908	5,592	1,373	3,926	2,442
98	3,077	3,945	5,659	1,389	3,981	2,479
99+	3,104	3,982	5,730	1,407	4,034	2,514

To calculate a household discount:

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

Modal premium **x** discount (.93)**= discounted premium**

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

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly.....0.0833

Aetna Health and Life Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of State

Male Rates

Rates effective 1/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,333	2,734	3,662	899	2,480	1,490
65	1,983	2,248	2,970	729	1,999	1,192
66	2,036	2,315	3,072	754	2,066	1,234
67	2,095	2,388	3,169	777	2,135	1,276
68	2,147	2,459	3,267	802	2,203	1,317
69	2,202	2,531	3,365	827	2,268	1,357
70	2,253	2,602	3,459	849	2,335	1,398
71	2,309	2,669	3,556	872	2,400	1,438
72	2,360	2,738	3,648	895	2,463	1,477
73	2,405	2,807	3,746	920	2,533	1,520
74	2,451	2,874	3,844	944	2,605	1,562
75	2,491	2,941	3,938	967	2,671	1,605
76	2,534	3,009	4,035	991	2,735	1,647
77	2,578	3,073	4,129	1,015	2,803	1,688
78	2,605	3,134	4,225	1,037	2,869	1,733
79	2,636	3,196	4,321	1,061	2,941	1,776
80	2,659	3,257	4,410	1,083	3,007	1,819
81	2,689	3,317	4,506	1,105	3,076	1,863
82	2,714	3,376	4,595	1,128	3,141	1,904
83	2,748	3,431	4,687	1,151	3,209	1,949
84	2,785	3,485	4,779	1,173	3,278	1,995
85	2,810	3,526	4,853	1,192	3,338	2,035
86	2,839	3,572	4,934	1,212	3,396	2,078
87	2,865	3,619	5,013	1,231	3,463	2,119
88	2,891	3,661	5,097	1,251	3,525	2,163
89	2,919	3,709	5,175	1,271	3,588	2,205
90	2,948	3,751	5,257	1,290	3,650	2,247
91	2,978	3,798	5,333	1,310	3,711	2,288
92	3,005	3,840	5,414	1,329	3,774	2,330
93	3,033	3,880	5,491	1,348	3,830	2,370
94	3,064	3,920	5,566	1,366	3,890	2,409
95	3,092	3,962	5,641	1,385	3,948	2,449
96	3,123	4,004	5,714	1,403	4,008	2,488
97	3,154	4,044	5,788	1,421	4,065	2,527
98	3,183	4,081	5,859	1,437	4,118	2,564
99+	3,212	4,120	5,930	1,455	4,175	2,603

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,592	3,038	4,069	999	2,756	2,756
65	2,202	2,496	3,302	810	2,220	1,324
66	2,266	2,577	3,413	838	2,296	1,371
67	2,326	2,656	3,522	865	2,373	1,417
68	2,388	2,733	3,633	892	2,446	1,465
69	2,450	2,811	3,740	918	2,521	1,508
70	2,506	2,891	3,844	944	2,594	1,552
71	2,564	2,966	3,950	970	2,667	1,597
72	2,624	3,042	4,054	995	2,740	1,639
73	2,674	3,117	4,162	1,021	2,815	1,688
74	2,721	3,192	4,271	1,049	2,893	1,736
75	2,771	3,268	4,376	1,074	2,966	1,785
76	2,817	3,340	4,482	1,101	3,039	1,830
77	2,865	3,415	4,587	1,127	3,115	1,875
78	2,892	3,484	4,696	1,152	3,188	1,925
79	2,926	3,549	4,800	1,178	3,268	1,972
80	2,956	3,619	4,901	1,204	3,342	2,020
81	2,987	3,686	5,005	1,228	3,416	2,067
82	3,017	3,751	5,106	1,253	3,487	2,116
83	3,057	3,812	5,206	1,279	3,566	2,165
84	3,092	3,874	5,308	1,301	3,642	2,216
85	3,123	3,917	5,394	1,324	3,709	2,260
86	3,154	3,968	5,483	1,346	3,776	2,307
87	3,182	4,021	5,568	1,368	3,847	2,355
88	3,212	4,069	5,666	1,390	3,916	2,403
89	3,245	4,120	5,750	1,412	3,988	2,450
90	3,274	4,169	5,840	1,434	4,054	2,496
91	3,308	4,220	5,929	1,457	4,125	2,543
92	3,339	4,264	6,017	1,477	4,192	2,589
93	3,371	4,315	6,102	1,499	4,258	2,633
94	3,403	4,357	6,184	1,518	4,323	2,678
95	3,437	4,405	6,269	1,539	4,388	2,721
96	3,469	4,448	6,348	1,558	4,452	2,763
97	3,507	4,492	6,431	1,579	4,516	2,808
98	3,540	4,535	6,508	1,597	4,577	2,850
99+	3,570	4,580	6,591	1,617	4,638	2,891

To calculate a household discount:

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

Modal premium **x** discount (.93)**= discounted premium**

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

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

PREMIUM INFORMATION

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

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

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

HOUSEHOLD DISCOUNT

In order to be eligible for the Household discount under an Aetna Health and Life Insurance Company Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently be covered by an Aetna Health and Life Insurance Company Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (b) be someone with whom you are in a civil union partnership; or (c) be a permanent resident in your home. The household discount will only be applicable if a policy for each applicant is issued. The discounted rate will be 7 percent lower than the individual rates and, the discount shall remain in effect for the life of the policy.

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$0	$1,632 (Part A Deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN A

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN B

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN F

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE PLAN F

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

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

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN G

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN N

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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