Outline of coverage

Medicare Supplement Insurance

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

Oklahoma

Underwritten by

Aetna Health Insurance Company

AetnaSeniorProducts.com

AHCMS05285OK

Rates effective: 01/2023 B

AETNA HEALTH 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" 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 2023[2]					**$6,940[2]**	**$3,470[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,700** 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: 730-731, 741
Female rates

Rates effective 1/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,599	-	-	-	-	-
65	1,599	1,515	1,830	594	1,474	1,037
66	1,601	1,516	1,832	595	1,475	1,038
67	1,602	1,517	1,833	596	1,476	1,039
68	1,619	1,535	1,853	603	1,494	1,077
69	1,657	1,569	1,895	616	1,527	1,120
70	1,699	1,610	1,945	632	1,567	1,163
71	1,751	1,660	2,003	652	1,616	1,204
72	1,805	1,710	2,066	672	1,664	1,246
73	1,863	1,766	2,134	693	1,718	1,287
74	1,931	1,827	2,209	718	1,779	1,331
75	1,998	1,892	2,286	742	1,842	1,374
76	2,067	1,958	2,366	769	1,906	1,418
77	2,141	2,027	2,448	795	1,972	1,466
78	2,212	2,096	2,533	823	2,041	1,515
79	2,281	2,161	2,613	848	2,104	1,564
80	2,353	2,229	2,694	876	2,171	1,616
81	2,428	2,300	2,777	903	2,239	1,666
82	2,500	2,367	2,862	930	2,307	1,716
83	2,577	2,442	2,948	958	2,377	1,769
84	2,651	2,512	3,037	987	2,445	1,820
85	2,749	2,604	3,144	1,023	2,535	1,887
86	2,826	2,679	3,236	1,052	2,608	1,941
87	2,906	2,754	3,325	1,081	2,682	1,995
88	2,989	2,830	3,421	1,111	2,755	2,050
89	3,070	2,910	3,515	1,143	2,835	2,108
90	3,157	2,991	3,612	1,174	2,912	2,165
91	3,242	3,070	3,711	1,205	2,989	2,225
92	3,327	3,156	3,809	1,238	3,072	2,286
93	3,418	3,239	3,912	1,272	3,153	2,346
94	3,507	3,322	4,015	1,305	3,235	2,408
95	3,600	3,412	4,120	1,339	3,321	2,472
96	3,693	3,497	4,226	1,373	3,404	2,535
97	3,788	3,588	4,334	1,409	3,494	2,600
98	3,883	3,677	4,444	1,444	3,581	2,665
99+	3,979	3,770	4,554	1,480	3,670	2,732

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,777	-	-	-	-	-
65	1,777	1,685	2,035	660	1,639	1,152
66	1,778	1,686	2,036	661	1,641	1,153
67	1,779	1,687	2,037	662	1,642	1,155
68	1,799	1,703	2,058	670	1,659	1,196
69	1,839	1,743	2,106	684	1,698	1,246
70	1,887	1,790	2,161	704	1,741	1,293
71	1,945	1,845	2,226	724	1,795	1,339
72	2,006	1,900	2,297	746	1,849	1,383
73	2,071	1,962	2,372	771	1,909	1,431
74	2,145	2,031	2,454	797	1,979	1,480
75	2,220	2,102	2,539	825	2,046	1,526
76	2,298	2,175	2,629	854	2,118	1,575
77	2,378	2,253	2,721	885	2,192	1,629
78	2,458	2,328	2,813	914	2,268	1,683
79	2,535	2,401	2,900	943	2,336	1,738
80	2,616	2,476	2,994	973	2,413	1,795
81	2,697	2,556	3,086	1,003	2,488	1,852
82	2,776	2,631	3,178	1,032	2,562	1,907
83	2,864	2,711	3,278	1,065	2,638	1,966
84	2,946	2,792	3,373	1,097	2,719	2,024
85	3,053	2,892	3,495	1,136	2,816	2,096
86	3,140	2,978	3,596	1,169	2,898	2,156
87	3,231	3,060	3,697	1,201	2,979	2,217
88	3,320	3,144	3,801	1,234	3,061	2,278
89	3,413	3,234	3,907	1,270	3,148	2,341
90	3,506	3,321	4,013	1,305	3,232	2,407
91	3,602	3,413	4,122	1,339	3,322	2,474
92	3,699	3,505	4,235	1,375	3,411	2,539
93	3,797	3,599	4,346	1,414	3,504	2,606
94	3,898	3,693	4,460	1,449	3,594	2,675
95	3,999	3,790	4,577	1,487	3,689	2,744
96	4,103	3,886	4,696	1,526	3,783	2,817
97	4,208	3,986	4,817	1,565	3,879	2,889
98	4,314	4,086	4,937	1,605	3,981	2,961
99+	4,422	4,188	5,061	1,644	4,078	3,036

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

To calculate a 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: 730-731, 734
Male rates

Rates effective 1/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,839	-	-	-	-	-
65	1,839	1,742	2,105	683	1,696	1,193
66	1,840	1,743	2,106	684	1,698	1,194
67	1,841	1,745	2,107	685	1,699	1,196
68	1,861	1,764	2,130	692	1,716	1,238
69	1,904	1,804	2,181	708	1,757	1,288
70	1,954	1,852	2,238	727	1,804	1,338
71	2,013	1,908	2,305	750	1,857	1,385
72	2,077	1,966	2,377	773	1,915	1,432
73	2,144	2,031	2,454	797	1,977	1,481
74	2,220	2,102	2,539	826	2,047	1,530
75	2,298	2,175	2,630	854	2,118	1,580
76	2,378	2,252	2,721	885	2,192	1,631
77	2,460	2,331	2,816	915	2,269	1,685
78	2,546	2,411	2,914	946	2,347	1,742
79	2,624	2,486	3,003	975	2,420	1,799
80	2,706	2,565	3,099	1,007	2,497	1,858
81	2,792	2,644	3,195	1,040	2,574	1,917
82	2,875	2,722	3,292	1,068	2,652	1,973
83	2,961	2,808	3,390	1,103	2,732	2,034
84	3,050	2,889	3,492	1,135	2,811	2,093
85	3,162	2,995	3,618	1,176	2,915	2,171
86	3,250	3,079	3,723	1,210	2,997	2,232
87	3,345	3,168	3,824	1,243	3,084	2,295
88	3,437	3,255	3,934	1,278	3,169	2,360
89	3,533	3,347	4,042	1,314	3,259	2,425
90	3,628	3,438	4,155	1,351	3,346	2,492
91	3,728	3,533	4,267	1,387	3,439	2,559
92	3,830	3,627	4,383	1,423	3,529	2,628
93	3,929	3,725	4,498	1,463	3,626	2,699
94	4,034	3,821	4,617	1,500	3,720	2,770
95	4,139	3,923	4,738	1,540	3,818	2,841
96	4,247	4,023	4,860	1,579	3,915	2,915
97	4,356	4,126	4,985	1,620	4,015	2,991
98	4,464	4,229	5,111	1,661	4,119	3,065
99+	4,576	4,335	5,239	1,702	4,220	3,142

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,043	-	-	-	-	-
65	2,043	1,938	2,339	759	1,886	1,326
66	2,044	1,939	2,340	760	1,887	1,327
67	2,046	1,940	2,343	761	1,888	1,328
68	2,068	1,960	2,367	770	1,908	1,375
69	2,116	2,004	2,422	786	1,952	1,432
70	2,171	2,057	2,486	809	2,002	1,487
71	2,238	2,120	2,561	833	2,064	1,541
72	2,307	2,185	2,641	859	2,125	1,592
73	2,382	2,258	2,728	887	2,197	1,644
74	2,468	2,336	2,822	918	2,273	1,701
75	2,554	2,416	2,921	948	2,353	1,755
76	2,642	2,501	3,022	982	2,435	1,811
77	2,735	2,589	3,129	1,016	2,521	1,872
78	2,826	2,679	3,236	1,051	2,609	1,934
79	2,916	2,760	3,335	1,084	2,688	1,998
80	3,007	2,849	3,441	1,119	2,777	2,065
81	3,103	2,940	3,550	1,155	2,861	2,130
82	3,192	3,024	3,657	1,188	2,945	2,193
83	3,294	3,120	3,768	1,225	3,036	2,260
84	3,388	3,208	3,879	1,260	3,126	2,326
85	3,510	3,325	4,020	1,307	3,238	2,412
86	3,612	3,423	4,135	1,344	3,332	2,480
87	3,715	3,518	4,251	1,381	3,427	2,550
88	3,819	3,618	4,370	1,420	3,522	2,620
89	3,924	3,718	4,492	1,461	3,621	2,696
90	4,033	3,820	4,615	1,500	3,718	2,769
91	4,142	3,924	4,740	1,540	3,819	2,845
92	4,253	4,032	4,869	1,582	3,924	2,919
93	4,368	4,137	4,998	1,626	4,027	2,998
94	4,483	4,247	5,130	1,668	4,134	3,077
95	4,600	4,358	5,264	1,711	4,243	3,158
96	4,720	4,470	5,400	1,755	4,351	3,238
97	4,838	4,584	5,538	1,800	4,461	3,322
98	4,960	4,699	5,679	1,846	4,576	3,406
99+	5,085	4,817	5,820	1,890	4,690	3,491

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

To calculate a 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 1/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,481	-	-	-	-	-
65	1,481	1,403	1,694	550	1,365	960
66	1,482	1,404	1,696	551	1,366	961
67	1,483	1,405	1,697	552	1,367	962
68	1,499	1,421	1,716	558	1,383	997
69	1,534	1,453	1,755	570	1,414	1,037
70	1,573	1,491	1,801	585	1,451	1,077
71	1,621	1,537	1,855	604	1,496	1,115
72	1,671	1,583	1,913	622	1,541	1,154
73	1,725	1,635	1,976	642	1,591	1,192
74	1,788	1,692	2,045	665	1,647	1,232
75	1,850	1,752	2,117	687	1,706	1,272
76	1,914	1,813	2,191	712	1,765	1,313
77	1,982	1,877	2,267	736	1,826	1,357
78	2,048	1,941	2,345	762	1,890	1,403
79	2,112	2,001	2,419	785	1,948	1,448
80	2,179	2,064	2,494	811	2,010	1,496
81	2,248	2,130	2,571	836	2,073	1,543
82	2,315	2,192	2,650	861	2,136	1,589
83	2,386	2,261	2,730	887	2,201	1,638
84	2,455	2,326	2,812	914	2,264	1,685
85	2,545	2,411	2,911	947	2,347	1,747
86	2,617	2,481	2,996	974	2,415	1,797
87	2,691	2,550	3,079	1,001	2,483	1,847
88	2,768	2,620	3,168	1,029	2,551	1,898
89	2,843	2,694	3,255	1,058	2,625	1,952
90	2,923	2,769	3,344	1,087	2,696	2,005
91	3,002	2,843	3,436	1,116	2,768	2,060
92	3,081	2,922	3,527	1,146	2,844	2,117
93	3,165	2,999	3,622	1,178	2,919	2,172
94	3,247	3,076	3,718	1,208	2,995	2,230
95	3,333	3,159	3,815	1,240	3,075	2,289
96	3,419	3,238	3,913	1,271	3,152	2,347
97	3,507	3,322	4,013	1,305	3,235	2,407
98	3,595	3,405	4,115	1,337	3,316	2,468
99+	3,684	3,491	4,217	1,370	3,398	2,530

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,645	-	-	-	-	-
65	1,645	1,560	1,884	611	1,518	1,067
66	1,646	1,561	1,885	612	1,519	1,068
67	1,647	1,562	1,886	613	1,520	1,069
68	1,666	1,577	1,906	620	1,536	1,107
69	1,703	1,614	1,950	633	1,572	1,154
70	1,747	1,657	2,001	652	1,612	1,197
71	1,801	1,708	2,061	670	1,662	1,240
72	1,857	1,759	2,127	691	1,712	1,281
73	1,918	1,817	2,196	714	1,768	1,325
74	1,986	1,881	2,272	738	1,832	1,370
75	2,056	1,946	2,351	764	1,894	1,413
76	2,128	2,014	2,434	791	1,961	1,458
77	2,202	2,086	2,519	819	2,030	1,508
78	2,276	2,156	2,605	846	2,100	1,558
79	2,347	2,223	2,685	873	2,163	1,609
80	2,422	2,293	2,772	901	2,234	1,662
81	2,497	2,367	2,857	929	2,304	1,715
82	2,570	2,436	2,943	956	2,372	1,766
83	2,652	2,510	3,035	986	2,443	1,820
84	2,728	2,585	3,123	1,016	2,518	1,874
85	2,827	2,678	3,236	1,052	2,607	1,941
86	2,907	2,757	3,330	1,082	2,683	1,996
87	2,992	2,833	3,423	1,112	2,758	2,053
88	3,074	2,911	3,519	1,143	2,834	2,109
89	3,160	2,994	3,618	1,176	2,915	2,168
90	3,246	3,075	3,716	1,208	2,993	2,229
91	3,335	3,160	3,817	1,240	3,076	2,291
92	3,425	3,245	3,921	1,273	3,158	2,351
93	3,516	3,332	4,024	1,309	3,244	2,413
94	3,609	3,419	4,130	1,342	3,328	2,477
95	3,703	3,509	4,238	1,377	3,416	2,541
96	3,799	3,598	4,348	1,413	3,503	2,608
97	3,896	3,691	4,460	1,449	3,592	2,675
98	3,994	3,783	4,571	1,486	3,686	2,742
99+	4,094	3,878	4,686	1,522	3,776	2,811

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

To calculate a 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 1/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,703	-	-	-	-	-
65	1,703	1,613	1,949	632	1,570	1,105
66	1,704	1,614	1,950	633	1,572	1,106
67	1,705	1,616	1,951	634	1,573	1,107
68	1,723	1,633	1,972	641	1,589	1,146
69	1,763	1,670	2,019	656	1,627	1,193
70	1,809	1,715	2,072	673	1,670	1,239
71	1,864	1,767	2,134	694	1,719	1,282
72	1,923	1,820	2,201	716	1,773	1,326
73	1,985	1,881	2,272	738	1,831	1,371
74	2,056	1,946	2,351	765	1,895	1,417
75	2,128	2,014	2,435	791	1,961	1,463
76	2,202	2,085	2,519	819	2,030	1,510
77	2,278	2,158	2,607	847	2,101	1,560
78	2,357	2,232	2,698	876	2,173	1,613
79	2,430	2,302	2,781	903	2,241	1,666
80	2,506	2,375	2,869	932	2,312	1,720
81	2,585	2,448	2,958	963	2,383	1,775
82	2,662	2,520	3,048	989	2,456	1,827
83	2,742	2,600	3,139	1,021	2,530	1,883
84	2,824	2,675	3,233	1,051	2,603	1,938
85	2,928	2,773	3,350	1,089	2,699	2,010
86	3,009	2,851	3,447	1,120	2,775	2,067
87	3,097	2,933	3,541	1,151	2,856	2,125
88	3,182	3,014	3,643	1,183	2,934	2,185
89	3,271	3,099	3,743	1,217	3,018	2,245
90	3,359	3,183	3,847	1,251	3,098	2,307
91	3,452	3,271	3,951	1,284	3,184	2,369
92	3,546	3,358	4,058	1,318	3,268	2,433
93	3,638	3,449	4,165	1,355	3,357	2,499
94	3,735	3,538	4,275	1,389	3,444	2,565
95	3,832	3,632	4,387	1,426	3,535	2,631
96	3,932	3,725	4,500	1,462	3,625	2,699
97	4,033	3,820	4,616	1,500	3,718	2,769
98	4,133	3,916	4,732	1,538	3,814	2,838
99+	4,237	4,014	4,851	1,576	3,907	2,909

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,892	-	-	-	-	-
65	1,892	1,794	2,166	703	1,746	1,228
66	1,893	1,795	2,167	704	1,747	1,229
67	1,894	1,796	2,169	705	1,748	1,230
68	1,915	1,815	2,192	713	1,767	1,273
69	1,959	1,856	2,243	728	1,807	1,326
70	2,010	1,905	2,302	749	1,854	1,377
71	2,072	1,963	2,371	771	1,911	1,427
72	2,136	2,023	2,445	795	1,968	1,474
73	2,206	2,091	2,526	821	2,034	1,522
74	2,285	2,163	2,613	850	2,105	1,575
75	2,365	2,237	2,705	878	2,179	1,625
76	2,446	2,316	2,798	909	2,255	1,677
77	2,532	2,397	2,897	941	2,334	1,733
78	2,617	2,481	2,996	973	2,416	1,791
79	2,700	2,556	3,088	1,004	2,489	1,850
80	2,784	2,638	3,186	1,036	2,571	1,912
81	2,873	2,722	3,287	1,069	2,649	1,972
82	2,956	2,800	3,386	1,100	2,727	2,031
83	3,050	2,889	3,489	1,134	2,811	2,093
84	3,137	2,970	3,592	1,167	2,894	2,154
85	3,250	3,079	3,722	1,210	2,998	2,233
86	3,344	3,169	3,829	1,244	3,085	2,296
87	3,440	3,257	3,936	1,279	3,173	2,361
88	3,536	3,350	4,046	1,315	3,261	2,426
89	3,633	3,443	4,159	1,353	3,353	2,496
90	3,734	3,537	4,273	1,389	3,443	2,564
91	3,835	3,633	4,389	1,426	3,536	2,634
92	3,938	3,733	4,508	1,465	3,633	2,703
93	4,044	3,831	4,628	1,506	3,729	2,776
94	4,151	3,932	4,750	1,544	3,828	2,849
95	4,259	4,035	4,874	1,584	3,929	2,924
96	4,370	4,139	5,000	1,625	4,029	2,998
97	4,480	4,244	5,128	1,667	4,131	3,076
98	4,593	4,351	5,258	1,709	4,237	3,154
99+	4,708	4,460	5,389	1,750	4,343	3,232

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

To calculate a 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 must currently be covered by an Aetna Company Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (b) 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 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.

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, 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 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 enrollment form 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 enrollment form 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 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 $1,600	$0	$1,600 (Part A Deductible)
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	$0	Up to $200 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.

***Deductible amounts announced annually by CMS

PLAN A

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

*Once you have been billed $226 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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$0	$226 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

***Deductible amounts announced annually by CMS

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 $1,600	$1,600 (Part A Deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	$0	Up to $200 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.

***Deductible amounts announced annually by CMS

PLAN B

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

*Once you have been billed $226 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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $1,600	$1,600 (Part A Deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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.

***Deductible amounts announced annually by CMS

PLAN F

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

*Once you have been billed $226 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 $226 of Medicare-Approved amounts*	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$226 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

***Deductible amounts announced annually by CMS

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

***Deductible amounts announced annually by CMS

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 $2,700 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,700. 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 $2,700 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,700 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,600	$1,600 (Part A Deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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.

***Deductible amounts announced annually by CMS

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $226 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 $2,700 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,700. 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 $2,700 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,700 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 $226 of Medicare-Approved amounts*	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$226 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

***Deductible amounts announced annually by CMS

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,700 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,700 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $226 of Medicare-Approved amounts*	$0	$226 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,700 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,700 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

***Deductible amounts announced annually by CMS

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 $1,600	$1,600 (Part A Deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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.

***Deductible amounts announced annually by CMS

PLAN G

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

*Once you have been billed $226 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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$0	$226 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

***Deductible amounts announced annually by CMS

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

***Deductible amounts announced annually by CMS

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 $1,600	$1,600 (Part A Deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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.

***Deductible amounts announced annually by CMS

PLAN N

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

*Once you have been billed $226 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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$0	$226 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

***Deductible amounts announced annually by CMS

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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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

***Deductible amounts announced annually by CMS