Outline of coverage

Medicare Supplement Insurance

Benefit plans: A, B, F, High Deductible F, G, N

Indiana

Underwritten by

Aetna Health and Life Insurance Company

aetnaseniorproducts.com

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Rates effective: 07/2020 B

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.
Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2021[2]					$6,220[2]	$3,110[2]				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,370 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

Aetna Health and Life Insurance Company

Annual Premiums

For Use in ZIP Codes: 463-464

Female Rates

Rates Effective 7/1/2020

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	7,749	---	---	---	---	---
65	1,409	1,489	2,194	679	1,491	1,436
66	1,409	1,489	2,194	679	1,491	1,436
67	1,409	1,489	2,194	679	1,491	1,436
68	1,423	1,505	2,217	686	1,507	1,487
69	1,457	1,539	2,268	702	1,540	1,549
70	1,495	1,580	2,328	720	1,581	1,607
71	1,539	1,626	2,398	742	1,630	1,663
72	1,589	1,679	2,473	766	1,680	1,720
73	1,640	1,733	2,553	791	1,735	1,778
74	1,698	1,795	2,642	819	1,796	1,840
75	1,757	1,857	2,734	847	1,858	1,899
76	1,819	1,922	2,830	877	1,923	1,959
77	1,883	1,989	2,930	907	1,991	2,024
78	1,946	2,056	3,030	938	2,058	2,091
79	2,008	2,122	3,124	967	2,124	2,159
80	2,071	2,188	3,222	999	2,190	2,232
81	2,136	2,256	3,325	1,029	2,259	2,301
82	2,199	2,322	3,423	1,060	2,327	2,370
83	2,268	2,395	3,529	1,093	2,398	2,443
84	2,334	2,465	3,632	1,125	2,467	2,515
85	2,417	2,554	3,764	1,166	2,558	2,605
86	2,487	2,627	3,872	1,199	2,630	2,681
87	2,558	2,702	3,981	1,233	2,705	2,755
88	2,629	2,778	4,094	1,268	2,782	2,833
89	2,703	2,855	4,206	1,304	2,859	2,912
90	2,776	2,934	4,322	1,339	2,936	2,992
91	2,851	3,014	4,440	1,375	3,016	3,074
92	2,929	3,095	4,559	1,413	3,097	3,156
93	3,007	3,177	4,681	1,450	3,181	3,240
94	3,087	3,261	4,805	1,488	3,264	3,326
95	3,168	3,345	4,931	1,528	3,349	3,414
96	3,249	3,434	5,058	1,566	3,437	3,501
97	3,333	3,521	5,186	1,605	3,524	3,590
98	3,416	3,609	5,319	1,646	3,612	3,682
99+	3,502	3,700	5,451	1,688	3,704	3,773

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	8,608	---	---	---	---	---
65	1,565	1,655	2,437	754	1,656	1,596
66	1,565	1,655	2,437	754	1,656	1,596
67	1,565	1,655	2,437	754	1,656	1,596
68	1,582	1,673	2,463	762	1,674	1,652
69	1,619	1,710	2,520	780	1,712	1,720
70	1,661	1,756	2,586	800	1,757	1,785
71	1,710	1,807	2,665	825	1,810	1,848
72	1,766	1,865	2,747	851	1,866	1,911
73	1,822	1,926	2,836	878	1,928	1,975
74	1,886	1,993	2,936	909	1,994	2,044
75	1,952	2,064	3,038	942	2,065	2,110
76	2,021	2,136	3,145	974	2,137	2,176
77	2,091	2,211	3,256	1,008	2,212	2,249
78	2,163	2,284	3,366	1,043	2,288	2,323
79	2,231	2,357	3,471	1,074	2,359	2,399
80	2,300	2,431	3,581	1,109	2,434	2,480
81	2,373	2,507	3,693	1,144	2,509	2,558
82	2,444	2,581	3,804	1,177	2,584	2,632
83	2,520	2,661	3,921	1,215	2,665	2,714
84	2,594	2,740	4,036	1,250	2,742	2,793
85	2,685	2,837	4,182	1,295	2,842	2,894
86	2,764	2,919	4,302	1,332	2,923	2,978
87	2,842	3,001	4,424	1,370	3,006	3,061
88	2,922	3,087	4,548	1,409	3,090	3,148
89	3,003	3,173	4,674	1,449	3,176	3,235
90	3,086	3,260	4,802	1,488	3,262	3,323
91	3,169	3,348	4,933	1,528	3,352	3,416
92	3,255	3,439	5,066	1,571	3,442	3,507
93	3,341	3,530	5,201	1,611	3,533	3,601
94	3,429	3,624	5,339	1,653	3,627	3,696
95	3,519	3,717	5,479	1,697	3,722	3,792
96	3,610	3,814	5,619	1,741	3,819	3,889
97	3,703	3,912	5,763	1,784	3,915	3,989
98	3,796	4,010	5,909	1,829	4,014	4,091
99+	3,891	4,111	6,058	1,877	4,116	4,193

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Aetna Health and Life Insurance Company

Annual Premiums

For Use in ZIP Codes: 463-464

Male Rates

Rates Effective 7/1/2020

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	8,910	---	---	---	---	---
65	1,621	1,713	2,523	781	1,714	1,652
66	1,621	1,713	2,523	781	1,714	1,652
67	1,621	1,713	2,523	781	1,714	1,652
68	1,638	1,731	2,549	790	1,733	1,709
69	1,676	1,770	2,608	807	1,771	1,781
70	1,719	1,818	2,677	828	1,819	1,848
71	1,770	1,870	2,758	855	1,873	1,913
72	1,827	1,930	2,844	880	1,931	1,979
73	1,886	1,992	2,935	908	1,995	2,045
74	1,952	2,064	3,038	942	2,065	2,115
75	2,021	2,136	3,145	974	2,137	2,184
76	2,091	2,210	3,255	1,008	2,212	2,253
77	2,166	2,289	3,369	1,044	2,290	2,328
78	2,238	2,364	3,485	1,079	2,368	2,405
79	2,310	2,439	3,593	1,112	2,442	2,482
80	2,381	2,516	3,706	1,148	2,518	2,566
81	2,457	2,595	3,825	1,184	2,598	2,647
82	2,529	2,670	3,937	1,218	2,676	2,725
83	2,608	2,754	4,059	1,256	2,758	2,810
84	2,684	2,835	4,177	1,293	2,837	2,892
85	2,781	2,937	4,328	1,340	2,942	2,996
86	2,861	3,022	4,452	1,378	3,025	3,082
87	2,942	3,108	4,579	1,418	3,111	3,169
88	3,024	3,195	4,707	1,458	3,198	3,258
89	3,109	3,283	4,837	1,499	3,287	3,348
90	3,193	3,374	4,971	1,539	3,377	3,441
91	3,279	3,466	5,106	1,581	3,468	3,536
92	3,367	3,560	5,243	1,624	3,562	3,630
93	3,458	3,654	5,384	1,667	3,659	3,726
94	3,550	3,750	5,526	1,712	3,754	3,826
95	3,642	3,848	5,671	1,756	3,852	3,925
96	3,735	3,949	5,816	1,801	3,952	4,025
97	3,833	4,048	5,965	1,847	4,053	4,128
98	3,929	4,150	6,116	1,893	4,155	4,234
99+	4,028	4,255	6,269	1,942	4,260	4,340

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	9,894	---	---	---	---	---
65	1,800	1,904	2,803	867	1,905	1,836
66	1,800	1,904	2,803	867	1,905	1,836
67	1,800	1,904	2,803	867	1,905	1,836
68	1,820	1,923	2,832	877	1,924	1,899
69	1,863	1,967	2,897	897	1,969	1,979
70	1,911	2,020	2,973	921	2,021	2,053
71	1,967	2,079	3,065	949	2,082	2,125
72	2,030	2,146	3,159	979	2,147	2,197
73	2,095	2,214	3,262	1,009	2,217	2,272
74	2,169	2,292	3,377	1,046	2,293	2,350
75	2,246	2,373	3,495	1,083	2,375	2,426
76	2,322	2,457	3,618	1,121	2,458	2,503
77	2,405	2,543	3,744	1,160	2,544	2,586
78	2,487	2,627	3,872	1,199	2,630	2,673
79	2,565	2,711	3,992	1,235	2,713	2,760
80	2,646	2,796	4,118	1,275	2,799	2,852
81	2,729	2,884	4,248	1,315	2,886	2,942
82	2,811	2,968	4,373	1,355	2,972	3,028
83	2,897	3,060	4,509	1,397	3,065	3,122
84	2,982	3,151	4,640	1,438	3,154	3,213
85	3,089	3,263	4,809	1,489	3,268	3,328
86	3,178	3,357	4,947	1,531	3,362	3,424
87	3,268	3,451	5,088	1,575	3,457	3,522
88	3,359	3,550	5,230	1,621	3,553	3,620
89	3,452	3,648	5,374	1,666	3,652	3,721
90	3,547	3,749	5,524	1,712	3,751	3,821
91	3,645	3,850	5,674	1,756	3,855	3,929
92	3,743	3,956	5,826	1,806	3,958	4,033
93	3,843	4,060	5,982	1,853	4,063	4,140
94	3,943	4,167	6,140	1,901	4,173	4,250
95	4,046	4,275	6,300	1,951	4,280	4,362
96	4,152	4,386	6,462	2,002	4,392	4,472
97	4,258	4,497	6,627	2,052	4,503	4,588
98	4,365	4,611	6,796	2,104	4,616	4,705
99+	4,474	4,727	6,966	2,158	4,733	4,822

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Aetna Health and Life Insurance Company

Annual Premiums

For Use in: Rest of State

Female Rates

Rates Effective 7/1/2020

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	6,680	---	---	---	---	---
65	1,215	1,284	1,891	585	1,285	1,238
66	1,215	1,284	1,891	585	1,285	1,238
67	1,215	1,284	1,891	585	1,285	1,238
68	1,227	1,297	1,911	591	1,299	1,282
69	1,256	1,327	1,955	605	1,328	1,335
70	1,289	1,362	2,007	621	1,363	1,385
71	1,327	1,402	2,067	640	1,405	1,434
72	1,370	1,447	2,132	660	1,448	1,483
73	1,414	1,494	2,201	682	1,496	1,533
74	1,464	1,547	2,278	706	1,548	1,586
75	1,515	1,601	2,357	730	1,602	1,637
76	1,568	1,657	2,440	756	1,658	1,689
77	1,623	1,715	2,526	782	1,716	1,745
78	1,678	1,772	2,612	809	1,774	1,803
79	1,731	1,829	2,693	834	1,831	1,861
80	1,785	1,886	2,778	861	1,888	1,924
81	1,841	1,945	2,866	887	1,947	1,984
82	1,896	2,002	2,951	914	2,006	2,043
83	1,955	2,065	3,042	942	2,067	2,106
84	2,012	2,125	3,131	970	2,127	2,168
85	2,084	2,202	3,245	1,005	2,205	2,246
86	2,144	2,265	3,338	1,034	2,267	2,311
87	2,205	2,329	3,432	1,063	2,332	2,375
88	2,266	2,395	3,529	1,093	2,398	2,442
89	2,330	2,461	3,626	1,124	2,465	2,510
90	2,393	2,529	3,726	1,154	2,531	2,579
91	2,458	2,598	3,828	1,185	2,600	2,650
92	2,525	2,668	3,930	1,218	2,670	2,721
93	2,592	2,739	4,035	1,250	2,742	2,793
94	2,661	2,811	4,142	1,283	2,814	2,867
95	2,731	2,884	4,251	1,317	2,887	2,943
96	2,801	2,960	4,360	1,350	2,963	3,018
97	2,873	3,035	4,471	1,384	3,038	3,095
98	2,945	3,111	4,585	1,419	3,114	3,174
99+	3,019	3,190	4,699	1,455	3,193	3,253

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	7,421	---	---	---	---	---
65	1,349	1,427	2,101	650	1,428	1,376
66	1,349	1,427	2,101	650	1,428	1,376
67	1,349	1,427	2,101	650	1,428	1,376
68	1,364	1,442	2,123	657	1,443	1,424
69	1,396	1,474	2,172	672	1,476	1,483
70	1,432	1,514	2,229	690	1,515	1,539
71	1,474	1,558	2,297	711	1,560	1,593
72	1,522	1,608	2,368	734	1,609	1,647
73	1,571	1,660	2,445	757	1,662	1,703
74	1,626	1,718	2,531	784	1,719	1,762
75	1,683	1,779	2,619	812	1,780	1,819
76	1,742	1,841	2,711	840	1,842	1,876
77	1,803	1,906	2,807	869	1,907	1,939
78	1,865	1,969	2,902	899	1,972	2,003
79	1,923	2,032	2,992	926	2,034	2,068
80	1,983	2,096	3,087	956	2,098	2,138
81	2,046	2,161	3,184	986	2,163	2,205
82	2,107	2,225	3,279	1,015	2,228	2,269
83	2,172	2,294	3,380	1,047	2,297	2,340
84	2,236	2,362	3,479	1,078	2,364	2,408
85	2,315	2,446	3,605	1,116	2,450	2,495
86	2,383	2,516	3,709	1,148	2,520	2,567
87	2,450	2,587	3,814	1,181	2,591	2,639
88	2,519	2,661	3,921	1,215	2,664	2,714
89	2,589	2,735	4,029	1,249	2,738	2,789
90	2,660	2,810	4,140	1,283	2,812	2,865
91	2,732	2,886	4,253	1,317	2,890	2,945
92	2,806	2,965	4,367	1,354	2,967	3,023
93	2,880	3,043	4,484	1,389	3,046	3,104
94	2,956	3,124	4,603	1,425	3,127	3,186
95	3,034	3,204	4,723	1,463	3,209	3,269
96	3,112	3,288	4,844	1,501	3,292	3,353
97	3,192	3,372	4,968	1,538	3,375	3,439
98	3,272	3,457	5,094	1,577	3,460	3,527
99+	3,354	3,544	5,222	1,618	3,548	3,615

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Aetna Health and Life Insurance Company

Annual Premiums

For Use in: Rest of State

Male Rates

Rates Effective 7/1/2020

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	7,681	---	---	---	---	---
65	1,397	1,477	2,175	673	1,478	1,424
66	1,397	1,477	2,175	673	1,478	1,424
67	1,397	1,477	2,175	673	1,478	1,424
68	1,412	1,492	2,197	681	1,494	1,473
69	1,445	1,526	2,248	696	1,527	1,535
70	1,482	1,567	2,308	714	1,568	1,593
71	1,526	1,612	2,378	737	1,615	1,649
72	1,575	1,664	2,452	759	1,665	1,706
73	1,626	1,717	2,530	783	1,720	1,763
74	1,683	1,779	2,619	812	1,780	1,823
75	1,742	1,841	2,711	840	1,842	1,883
76	1,803	1,905	2,806	869	1,907	1,942
77	1,867	1,973	2,904	900	1,974	2,007
78	1,929	2,038	3,004	930	2,041	2,073
79	1,991	2,103	3,097	959	2,105	2,140
80	2,053	2,169	3,195	990	2,171	2,212
81	2,118	2,237	3,297	1,021	2,240	2,282
82	2,180	2,302	3,394	1,050	2,307	2,349
83	2,248	2,374	3,499	1,083	2,378	2,422
84	2,314	2,444	3,601	1,115	2,446	2,493
85	2,397	2,532	3,731	1,155	2,536	2,583
86	2,466	2,605	3,838	1,188	2,608	2,657
87	2,536	2,679	3,947	1,222	2,682	2,732
88	2,607	2,754	4,058	1,257	2,757	2,809
89	2,680	2,830	4,170	1,292	2,834	2,886
90	2,753	2,909	4,285	1,327	2,911	2,966
91	2,827	2,988	4,402	1,363	2,990	3,048
92	2,903	3,069	4,520	1,400	3,071	3,129
93	2,981	3,150	4,641	1,437	3,154	3,212
94	3,060	3,233	4,764	1,476	3,236	3,298
95	3,140	3,317	4,889	1,514	3,321	3,384
96	3,220	3,404	5,014	1,553	3,407	3,470
97	3,304	3,490	5,142	1,592	3,494	3,559
98	3,387	3,578	5,272	1,632	3,582	3,650
99+	3,472	3,668	5,404	1,674	3,672	3,741

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	8,529	---	---	---	---	---
65	1,552	1,641	2,416	747	1,642	1,583
66	1,552	1,641	2,416	747	1,642	1,583
67	1,552	1,641	2,416	747	1,642	1,583
68	1,569	1,658	2,441	756	1,659	1,637
69	1,606	1,696	2,497	773	1,697	1,706
70	1,647	1,741	2,563	794	1,742	1,770
71	1,696	1,792	2,642	818	1,795	1,832
72	1,750	1,850	2,723	844	1,851	1,894
73	1,806	1,909	2,812	870	1,911	1,959
74	1,870	1,976	2,911	902	1,977	2,026
75	1,936	2,046	3,013	934	2,047	2,091
76	2,002	2,118	3,119	966	2,119	2,158
77	2,073	2,192	3,228	1,000	2,193	2,229
78	2,144	2,265	3,338	1,034	2,267	2,304
79	2,211	2,337	3,441	1,065	2,339	2,379
80	2,281	2,410	3,550	1,099	2,413	2,459
81	2,353	2,486	3,662	1,134	2,488	2,536
82	2,423	2,559	3,770	1,168	2,562	2,610
83	2,497	2,638	3,887	1,204	2,642	2,691
84	2,571	2,716	4,000	1,240	2,719	2,770
85	2,663	2,813	4,146	1,284	2,817	2,869
86	2,740	2,894	4,265	1,320	2,898	2,952
87	2,817	2,975	4,386	1,358	2,980	3,036
88	2,896	3,060	4,509	1,397	3,063	3,121
89	2,976	3,145	4,633	1,436	3,148	3,208
90	3,058	3,232	4,762	1,476	3,234	3,294
91	3,142	3,319	4,891	1,514	3,323	3,387
92	3,227	3,410	5,022	1,557	3,412	3,477
93	3,313	3,500	5,157	1,597	3,503	3,569
94	3,399	3,592	5,293	1,639	3,597	3,664
95	3,488	3,685	5,431	1,682	3,690	3,760
96	3,579	3,781	5,571	1,726	3,786	3,855
97	3,671	3,877	5,713	1,769	3,882	3,955
98	3,763	3,975	5,859	1,814	3,979	4,056
99+	3,857	4,075	6,005	1,860	4,080	4,157

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

PREMIUM INFORMATION

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

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

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

HOUSEHOLD DISCOUNT

In order to be eligible for the Household discount under an Aetna Health and Life Insurance Company Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently be covered by an Aetna 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 rate will be
7 percent lower than the individual rates and will apply as long as both policies remain in force.

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

The policy may not cover all of your medical costs.

Neither Aetna Health and Life Insurance Company nor its agents are connected with Medicare.

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER CALENDAR YEAR

*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 $1,484	$0	$1,484 (Part A Deductible)
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	$0	Up to $185.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

***Deductible amounts announced annually by CMS

PLAN A

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

*Once you have been billed $203 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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	$0	Up to $185.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

***Deductible amounts announced annually by CMS

PLAN B

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

* Once you have been billed $203 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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

***Deductible amounts announced annually by CMS

PLAN F

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

*Once you have been billed $203 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 $203 of Medicare-Approved amounts*	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$203 (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 $2,370 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses are $2,370. 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 $2,370 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,370 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

***Deductible amounts announced annually by CMS

HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

***Deductible amounts announced annually by CMS

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $203 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 $2,370deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses are $2,370. 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 $2,370 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,370 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 $203 of Medicare-Approved amounts*	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$203 (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 $2,370 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,370 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment •First $203 of Medicare Approved amounts*	$0	$203 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,370 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,370 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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

***Deductible amounts announced annually by CMS

PLAN G

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

*Once you have been billed $203 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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

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

***Deductible amounts announced annually by CMS

PLAN N

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

*Once you have been billed $203 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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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