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

AHLMS05287IN

Rates effective: 03/2021 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. 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 3/1/2021

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	8,366	---	---	---	---	---
65	1,522	1,609	2,369	679	1,610	1,551
66	1,522	1,609	2,369	679	1,610	1,551
67	1,522	1,609	2,369	679	1,610	1,551
68	1,537	1,625	2,394	686	1,627	1,607
69	1,573	1,662	2,449	702	1,663	1,673
70	1,615	1,706	2,515	720	1,708	1,735
71	1,662	1,756	2,589	742	1,760	1,797
72	1,717	1,813	2,671	766	1,814	1,858
73	1,771	1,872	2,757	791	1,875	1,921
74	1,834	1,938	2,854	819	1,940	1,987
75	1,898	2,006	2,953	847	2,007	2,051
76	1,964	2,076	3,057	877	2,078	2,116
77	2,033	2,148	3,164	907	2,149	2,187
78	2,102	2,220	3,272	938	2,223	2,259
79	2,168	2,291	3,373	967	2,293	2,332
80	2,236	2,363	3,480	999	2,365	2,410
81	2,306	2,437	3,590	1,029	2,439	2,486
82	2,376	2,508	3,697	1,060	2,513	2,559
83	2,449	2,587	3,811	1,093	2,589	2,638
84	2,521	2,662	3,922	1,125	2,665	2,716
85	2,611	2,758	4,066	1,166	2,762	2,814
86	2,687	2,837	4,182	1,199	2,840	2,895
87	2,762	2,917	4,300	1,233	2,922	2,975
88	2,839	3,001	4,421	1,268	3,004	3,059
89	2,919	3,083	4,543	1,304	3,088	3,145
90	2,997	3,168	4,668	1,339	3,170	3,231
91	3,080	3,255	4,795	1,375	3,257	3,320
92	3,163	3,342	4,923	1,413	3,345	3,409
93	3,247	3,431	5,055	1,450	3,435	3,499
94	3,334	3,522	5,189	1,488	3,525	3,591
95	3,421	3,613	5,326	1,528	3,617	3,686
96	3,509	3,709	5,462	1,566	3,712	3,780
97	3,599	3,802	5,602	1,605	3,806	3,878
98	3,690	3,898	5,744	1,646	3,901	3,976
99+	3,783	3,996	5,887	1,688	4,000	4,075

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	9,295	---	---	---	---	---
65	1,690	1,788	2,632	754	1,789	1,724
66	1,690	1,788	2,632	754	1,789	1,724
67	1,690	1,788	2,632	754	1,789	1,724
68	1,709	1,806	2,660	762	1,807	1,784
69	1,749	1,847	2,721	780	1,849	1,858
70	1,795	1,897	2,792	800	1,898	1,928
71	1,847	1,952	2,878	825	1,955	1,995
72	1,907	2,015	2,966	851	2,016	2,064
73	1,969	2,080	3,064	878	2,082	2,133
74	2,037	2,152	3,170	909	2,154	2,207
75	2,109	2,228	3,282	942	2,230	2,279
76	2,182	2,306	3,396	974	2,307	2,350
77	2,259	2,387	3,517	1,008	2,390	2,429
78	2,336	2,467	3,635	1,043	2,471	2,509
79	2,409	2,546	3,748	1,074	2,549	2,590
80	2,485	2,626	3,867	1,109	2,629	2,678
81	2,564	2,707	3,989	1,144	2,710	2,762
82	2,640	2,787	4,108	1,177	2,791	2,843
83	2,721	2,874	4,234	1,215	2,878	2,931
84	2,801	2,959	4,358	1,250	2,961	3,017
85	2,900	3,065	4,516	1,295	3,069	3,126
86	2,986	3,152	4,647	1,332	3,158	3,216
87	3,069	3,241	4,778	1,370	3,246	3,306
88	3,156	3,334	4,913	1,409	3,337	3,400
89	3,243	3,427	5,047	1,449	3,430	3,494
90	3,333	3,521	5,186	1,488	3,523	3,589
91	3,423	3,616	5,328	1,528	3,620	3,690
92	3,515	3,714	5,471	1,571	3,717	3,787
93	3,608	3,812	5,618	1,611	3,816	3,888
94	3,703	3,914	5,766	1,653	3,917	3,992
95	3,801	4,014	5,917	1,697	4,021	4,096
96	3,899	4,119	6,069	1,741	4,124	4,200
97	3,999	4,225	6,223	1,784	4,228	4,308
98	4,099	4,331	6,382	1,829	4,335	4,418
99+	4,202	4,440	6,542	1,877	4,445	4,529

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 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 Period, use Preferred rates.

Aetna Health and Life Insurance Company

Annual Premiums

For Use in ZIP Codes: 463-464

Male Rates

Rates Effective 3/1/2021

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	9,621	---	---	---	---	---
65	1,750	1,850	2,725	781	1,851	1,784
66	1,750	1,850	2,725	781	1,851	1,784
67	1,750	1,850	2,725	781	1,851	1,784
68	1,769	1,869	2,753	790	1,872	1,846
69	1,811	1,912	2,816	807	1,913	1,923
70	1,857	1,963	2,892	828	1,964	1,995
71	1,912	2,020	2,979	855	2,023	2,066
72	1,973	2,085	3,072	880	2,086	2,137
73	2,037	2,151	3,169	908	2,155	2,209
74	2,109	2,228	3,282	942	2,230	2,284
75	2,182	2,306	3,396	974	2,307	2,359
76	2,259	2,386	3,515	1,008	2,390	2,433
77	2,339	2,472	3,638	1,044	2,473	2,515
78	2,416	2,553	3,763	1,079	2,557	2,597
79	2,494	2,634	3,880	1,112	2,637	2,681
80	2,572	2,718	4,003	1,148	2,720	2,771
81	2,653	2,803	4,131	1,184	2,806	2,859
82	2,731	2,884	4,253	1,218	2,891	2,943
83	2,816	2,974	4,384	1,256	2,979	3,035
84	2,899	3,062	4,511	1,293	3,065	3,123
85	3,003	3,173	4,674	1,340	3,177	3,236
86	3,089	3,263	4,808	1,378	3,268	3,329
87	3,177	3,356	4,945	1,418	3,361	3,423
88	3,267	3,450	5,084	1,458	3,454	3,519
89	3,357	3,545	5,225	1,499	3,551	3,616
90	3,449	3,645	5,368	1,539	3,647	3,715
91	3,541	3,743	5,515	1,581	3,746	3,819
92	3,637	3,845	5,663	1,624	3,848	3,920
93	3,734	3,946	5,814	1,667	3,951	4,024
94	3,834	4,051	5,968	1,712	4,054	4,132
95	3,934	4,155	6,125	1,756	4,161	4,240
96	4,034	4,264	6,281	1,801	4,269	4,348
97	4,139	4,372	6,441	1,847	4,378	4,459
98	4,243	4,482	6,605	1,893	4,488	4,573
99+	4,350	4,595	6,770	1,942	4,601	4,686

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	10,684	---	---	---	---	---
65	1,944	2,056	3,026	867	2,057	1,984
66	1,944	2,056	3,026	867	2,057	1,984
67	1,944	2,056	3,026	867	2,057	1,984
68	1,966	2,078	3,058	877	2,079	2,051
69	2,011	2,125	3,129	897	2,126	2,137
70	2,064	2,181	3,211	921	2,182	2,218
71	2,125	2,245	3,309	949	2,249	2,296
72	2,192	2,318	3,412	979	2,319	2,373
73	2,262	2,392	3,523	1,009	2,394	2,455
74	2,343	2,475	3,647	1,046	2,477	2,538
75	2,426	2,564	3,775	1,083	2,565	2,619
76	2,508	2,653	3,908	1,121	2,655	2,704
77	2,597	2,746	4,044	1,160	2,747	2,792
78	2,687	2,837	4,182	1,199	2,840	2,886
79	2,770	2,928	4,311	1,235	2,930	2,980
80	2,857	3,019	4,447	1,275	3,023	3,081
81	2,948	3,115	4,588	1,315	3,117	3,177
82	3,036	3,206	4,724	1,355	3,210	3,270
83	3,129	3,305	4,870	1,397	3,309	3,371
84	3,221	3,402	5,011	1,438	3,407	3,471
85	3,336	3,524	5,194	1,489	3,529	3,595
86	3,432	3,626	5,343	1,531	3,631	3,698
87	3,529	3,727	5,495	1,575	3,733	3,804
88	3,628	3,834	5,649	1,621	3,837	3,910
89	3,728	3,941	5,805	1,666	3,944	4,019
90	3,831	4,050	5,966	1,712	4,052	4,127
91	3,936	4,159	6,127	1,756	4,163	4,243
92	4,043	4,272	6,292	1,806	4,275	4,356
93	4,150	4,385	6,461	1,853	4,388	4,472
94	4,258	4,500	6,631	1,901	4,507	4,590
95	4,370	4,617	6,803	1,951	4,623	4,711
96	4,483	4,736	6,980	2,002	4,743	4,829
97	4,599	4,857	7,157	2,052	4,864	4,954
98	4,714	4,980	7,340	2,104	4,985	5,081
99+	4,833	5,105	7,523	2,158	5,111	5,208

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 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 Period, use Preferred rates.

Aetna Health and Life Insurance Company

Annual Premiums

For Use in: Rest of State

Female Rates

Rates Effective 3/1/2021

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	7,212	-	-	-	-	-
65	1,312	1,387	2,042	585	1,388	1,337
66	1,312	1,387	2,042	585	1,388	1,337
67	1,312	1,387	2,042	585	1,388	1,337
68	1,325	1,401	2,064	591	1,403	1,385
69	1,356	1,433	2,111	605	1,434	1,442
70	1,392	1,471	2,168	621	1,472	1,496
71	1,433	1,514	2,232	640	1,517	1,549
72	1,480	1,563	2,303	660	1,564	1,602
73	1,527	1,614	2,377	682	1,616	1,656
74	1,581	1,671	2,460	706	1,672	1,713
75	1,636	1,729	2,546	730	1,730	1,768
76	1,693	1,790	2,635	756	1,791	1,824
77	1,753	1,852	2,728	782	1,853	1,885
78	1,812	1,914	2,821	809	1,916	1,947
79	1,869	1,975	2,908	834	1,977	2,010
80	1,928	2,037	3,000	861	2,039	2,078
81	1,988	2,101	3,095	887	2,103	2,143
82	2,048	2,162	3,187	914	2,166	2,206
83	2,111	2,230	3,285	942	2,232	2,274
84	2,173	2,295	3,381	970	2,297	2,341
85	2,251	2,378	3,505	1,005	2,381	2,426
86	2,316	2,446	3,605	1,034	2,448	2,496
87	2,381	2,515	3,707	1,063	2,519	2,565
88	2,447	2,587	3,811	1,093	2,590	2,637
89	2,516	2,658	3,916	1,124	2,662	2,711
90	2,584	2,731	4,024	1,154	2,733	2,785
91	2,655	2,806	4,134	1,185	2,808	2,862
92	2,727	2,881	4,244	1,218	2,884	2,939
93	2,799	2,958	4,358	1,250	2,961	3,016
94	2,874	3,036	4,473	1,283	3,039	3,096
95	2,949	3,115	4,591	1,317	3,118	3,178
96	3,025	3,197	4,709	1,350	3,200	3,259
97	3,103	3,278	4,829	1,384	3,281	3,343
98	3,181	3,360	4,952	1,419	3,363	3,428
99+	3,261	3,445	5,075	1,455	3,448	3,513

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	8,013	-	-	-	-	-
65	1,457	1,541	2,269	650	1,542	1,486
66	1,457	1,541	2,269	650	1,542	1,486
67	1,457	1,541	2,269	650	1,542	1,486
68	1,473	1,557	2,293	657	1,558	1,538
69	1,508	1,592	2,346	672	1,594	1,602
70	1,547	1,635	2,407	690	1,636	1,662
71	1,592	1,683	2,481	711	1,685	1,720
72	1,644	1,737	2,557	734	1,738	1,779
73	1,697	1,793	2,641	757	1,795	1,839
74	1,756	1,855	2,733	784	1,857	1,903
75	1,818	1,921	2,829	812	1,922	1,965
76	1,881	1,988	2,928	840	1,989	2,026
77	1,947	2,058	3,032	869	2,060	2,094
78	2,014	2,127	3,134	899	2,130	2,163
79	2,077	2,195	3,231	926	2,197	2,233
80	2,142	2,264	3,334	956	2,266	2,309
81	2,210	2,334	3,439	986	2,336	2,381
82	2,276	2,403	3,541	1,015	2,406	2,451
83	2,346	2,478	3,650	1,047	2,481	2,527
84	2,415	2,551	3,757	1,078	2,553	2,601
85	2,500	2,642	3,893	1,116	2,646	2,695
86	2,574	2,717	4,006	1,148	2,722	2,772
87	2,646	2,794	4,119	1,181	2,798	2,850
88	2,721	2,874	4,235	1,215	2,877	2,931
89	2,796	2,954	4,351	1,249	2,957	3,012
90	2,873	3,035	4,471	1,283	3,037	3,094
91	2,951	3,117	4,593	1,317	3,121	3,181
92	3,030	3,202	4,716	1,354	3,204	3,265
93	3,110	3,286	4,843	1,389	3,290	3,352
94	3,192	3,374	4,971	1,425	3,377	3,441
95	3,277	3,460	5,101	1,463	3,466	3,531
96	3,361	3,551	5,232	1,501	3,555	3,621
97	3,447	3,642	5,365	1,538	3,645	3,714
98	3,534	3,734	5,502	1,577	3,737	3,809
99+	3,622	3,828	5,640	1,618	3,832	3,904

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 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 Period, use Preferred rates.

Aetna Health and Life Insurance Company

Annual Premiums

For Use in: Rest of State

Male Rates

Rates Effective 3/1/2021

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	8,294	-	-	-	-	-
65	1,509	1,595	2,349	673	1,596	1,538
66	1,509	1,595	2,349	673	1,596	1,538
67	1,509	1,595	2,349	673	1,596	1,538
68	1,525	1,611	2,373	681	1,614	1,591
69	1,561	1,648	2,428	696	1,649	1,658
70	1,601	1,692	2,493	714	1,693	1,720
71	1,648	1,741	2,568	737	1,744	1,781
72	1,701	1,797	2,648	759	1,798	1,842
73	1,756	1,854	2,732	783	1,858	1,904
74	1,818	1,921	2,829	812	1,922	1,969
75	1,881	1,988	2,928	840	1,989	2,034
76	1,947	2,057	3,030	869	2,060	2,097
77	2,016	2,131	3,136	900	2,132	2,168
78	2,083	2,201	3,244	930	2,204	2,239
79	2,150	2,271	3,345	959	2,273	2,311
80	2,217	2,343	3,451	990	2,345	2,389
81	2,287	2,416	3,561	1,021	2,419	2,465
82	2,354	2,486	3,666	1,050	2,492	2,537
83	2,428	2,564	3,779	1,083	2,568	2,616
84	2,499	2,640	3,889	1,115	2,642	2,692
85	2,589	2,735	4,029	1,155	2,739	2,790
86	2,663	2,813	4,145	1,188	2,817	2,870
87	2,739	2,893	4,263	1,222	2,897	2,951
88	2,816	2,974	4,383	1,257	2,978	3,034
89	2,894	3,056	4,504	1,292	3,061	3,117
90	2,973	3,142	4,628	1,327	3,144	3,203
91	3,053	3,227	4,754	1,363	3,229	3,292
92	3,135	3,315	4,882	1,400	3,317	3,379
93	3,219	3,402	5,012	1,437	3,406	3,469
94	3,305	3,492	5,145	1,476	3,495	3,562
95	3,391	3,582	5,280	1,514	3,587	3,655
96	3,478	3,676	5,415	1,553	3,680	3,748
97	3,568	3,769	5,553	1,592	3,774	3,844
98	3,658	3,864	5,694	1,632	3,869	3,942
99+	3,750	3,961	5,836	1,674	3,966	4,040

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	9,210	-	-	-	-	-
65	1,676	1,772	2,609	747	1,773	1,710
66	1,676	1,772	2,609	747	1,773	1,710
67	1,676	1,772	2,609	747	1,773	1,710
68	1,695	1,791	2,636	756	1,792	1,768
69	1,734	1,832	2,697	773	1,833	1,842
70	1,779	1,880	2,768	794	1,881	1,912
71	1,832	1,935	2,853	818	1,939	1,979
72	1,890	1,998	2,941	844	1,999	2,046
73	1,950	2,062	3,037	870	2,064	2,116
74	2,020	2,134	3,144	902	2,135	2,188
75	2,091	2,210	3,254	934	2,211	2,258
76	2,162	2,287	3,369	966	2,289	2,331
77	2,239	2,367	3,486	1,000	2,368	2,407
78	2,316	2,446	3,605	1,034	2,448	2,488
79	2,388	2,524	3,716	1,065	2,526	2,569
80	2,463	2,603	3,834	1,099	2,606	2,656
81	2,541	2,685	3,955	1,134	2,687	2,739
82	2,617	2,764	4,072	1,168	2,767	2,819
83	2,697	2,849	4,198	1,204	2,853	2,906
84	2,777	2,933	4,320	1,240	2,937	2,992
85	2,876	3,038	4,478	1,284	3,042	3,099
86	2,959	3,126	4,606	1,320	3,130	3,188
87	3,042	3,213	4,737	1,358	3,218	3,279
88	3,128	3,305	4,870	1,397	3,308	3,371
89	3,214	3,397	5,004	1,436	3,400	3,465
90	3,303	3,491	5,143	1,476	3,493	3,558
91	3,393	3,585	5,282	1,514	3,589	3,658
92	3,485	3,683	5,424	1,557	3,685	3,755
93	3,578	3,780	5,570	1,597	3,783	3,855
94	3,671	3,879	5,716	1,639	3,885	3,957
95	3,767	3,980	5,865	1,682	3,985	4,061
96	3,865	4,083	6,017	1,726	4,089	4,163
97	3,965	4,187	6,170	1,769	4,193	4,271
98	4,064	4,293	6,328	1,814	4,297	4,380
99+	4,166	4,401	6,485	1,860	4,406	4,490

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 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 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