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: 01/2025 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 2025[2]					**$7,220[2]**	**$3,610[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,870** 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 1/1/2025

ATTAINED AGE	PREFERRED						STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,971	2,083	6,134	1,357	4,169	4,016	2,189	2,315	6,818	1,508	4,633	4,466
65	1,971	2,083	3,067	679	2,085	2,008	2,189	2,315	3,409	754	2,317	2,233
66	1,971	2,083	3,067	679	2,085	2,008	2,189	2,315	3,409	754	2,317	2,233
67	1,971	2,083	3,067	679	2,085	2,008	2,189	2,315	3,409	754	2,317	2,233
68	1,991	2,104	3,102	686	2,108	2,081	2,214	2,340	3,444	762	2,341	2,310
69	2,037	2,153	3,171	702	2,154	2,166	2,265	2,391	3,524	780	2,393	2,406
70	2,091	2,209	3,257	720	2,210	2,248	2,323	2,456	3,616	800	2,457	2,497
71	2,153	2,275	3,354	742	2,279	2,327	2,391	2,528	3,726	825	2,531	2,584
72	2,223	2,348	3,459	766	2,349	2,406	2,470	2,609	3,841	851	2,610	2,673
73	2,293	2,424	3,570	791	2,427	2,487	2,551	2,694	3,967	878	2,697	2,763
74	2,375	2,510	3,695	819	2,511	2,573	2,638	2,786	4,105	909	2,790	2,858
75	2,457	2,598	3,825	847	2,600	2,655	2,731	2,885	4,251	942	2,888	2,952
76	2,543	2,689	3,958	877	2,691	2,740	2,826	2,987	4,399	974	2,988	3,044
77	2,633	2,783	4,099	907	2,784	2,833	2,924	3,091	4,554	1,008	3,094	3,145
78	2,723	2,876	4,239	938	2,878	2,924	3,025	3,195	4,707	1,043	3,200	3,249
79	2,807	2,967	4,369	967	2,970	3,019	3,120	3,298	4,855	1,074	3,301	3,355
80	2,897	3,060	4,507	999	3,064	3,122	3,218	3,401	5,008	1,109	3,403	3,470
81	2,987	3,156	4,650	1,029	3,159	3,219	3,320	3,507	5,167	1,144	3,509	3,577
82	3,076	3,248	4,788	1,060	3,254	3,314	3,419	3,610	5,320	1,177	3,615	3,682
83	3,171	3,351	4,935	1,093	3,354	3,416	3,524	3,722	5,483	1,215	3,726	3,796
84	3,264	3,448	5,080	1,125	3,451	3,517	3,627	3,833	5,645	1,250	3,835	3,907
85	3,383	3,572	5,265	1,166	3,577	3,644	3,755	3,970	5,848	1,295	3,975	4,048
86	3,479	3,675	5,415	1,199	3,677	3,750	3,867	4,083	6,018	1,332	4,089	4,163
87	3,577	3,778	5,569	1,233	3,784	3,854	3,975	4,197	6,187	1,370	4,204	4,283
88	3,676	3,887	5,726	1,268	3,891	3,961	4,088	4,318	6,361	1,409	4,322	4,403
89	3,779	3,993	5,882	1,304	4,000	4,073	4,200	4,438	6,537	1,449	4,442	4,524
90	3,883	4,103	6,045	1,339	4,105	4,184	4,316	4,560	6,716	1,488	4,562	4,647
91	3,988	4,215	6,211	1,375	4,218	4,300	4,435	4,683	6,900	1,528	4,689	4,778
92	4,096	4,328	6,375	1,413	4,333	4,415	4,552	4,809	7,084	1,571	4,813	4,904
93	4,205	4,443	6,547	1,450	4,447	4,530	4,672	4,936	7,276	1,611	4,943	5,036
94	4,318	4,561	6,720	1,488	4,566	4,652	4,794	5,069	7,468	1,653	5,073	5,170
95	4,429	4,679	6,896	1,528	4,684	4,775	4,922	5,197	7,662	1,697	5,207	5,305
96	4,544	4,804	7,075	1,566	4,807	4,895	5,048	5,335	7,859	1,741	5,341	5,439
97	4,661	4,925	7,255	1,605	4,929	5,022	5,178	5,471	8,060	1,784	5,476	5,578
98	4,778	5,047	7,440	1,646	5,053	5,150	5,309	5,609	8,265	1,829	5,614	5,722
99+	4,899	5,175	7,625	1,688	5,179	5,278	5,440	5,751	8,473	1,877	5,757	5,864

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 and Life Insurance Company

Annual Premiums

For Use in ZIP Codes: 463-464

Male Rates

Rates effective 1/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,267	2,398	7,055	1,561	4,798	4,619
65	2,267	2,398	3,528	781	2,399	2,310
66	2,267	2,398	3,528	781	2,399	2,310
67	2,267	2,398	3,528	781	2,399	2,310
68	2,291	2,420	3,566	790	2,424	2,390
69	2,344	2,475	3,648	807	2,477	2,491
70	2,405	2,542	3,746	828	2,543	2,584
71	2,475	2,616	3,858	855	2,619	2,675
72	2,555	2,699	3,978	880	2,700	2,768
73	2,638	2,785	4,104	908	2,791	2,861
74	2,731	2,885	4,251	942	2,888	2,958
75	2,826	2,987	4,399	974	2,988	3,057
76	2,924	3,090	4,552	1,008	3,094	3,151
77	3,029	3,202	4,711	1,044	3,203	3,257
78	3,129	3,306	4,873	1,079	3,311	3,364
79	3,231	3,412	5,025	1,112	3,415	3,472
80	3,332	3,521	5,185	1,148	3,523	3,588
81	3,436	3,628	5,349	1,184	3,634	3,704
82	3,537	3,735	5,508	1,218	3,742	3,811
83	3,648	3,852	5,677	1,256	3,858	3,930
84	3,754	3,966	5,843	1,293	3,970	4,044
85	3,889	4,108	6,053	1,340	4,116	4,191
86	4,001	4,226	6,227	1,378	4,232	4,312
87	4,116	4,345	6,404	1,418	4,352	4,435
88	4,229	4,468	6,584	1,458	4,473	4,558
89	4,347	4,591	6,766	1,499	4,597	4,683
90	4,467	4,720	6,953	1,539	4,722	4,811
91	4,588	4,848	7,141	1,581	4,851	4,945
92	4,710	4,979	7,334	1,624	4,983	5,075
93	4,836	5,111	7,530	1,667	5,117	5,211
94	4,964	5,246	7,729	1,712	5,251	5,351
95	5,095	5,380	7,932	1,756	5,389	5,491
96	5,225	5,523	8,134	1,801	5,527	5,631
97	5,360	5,662	8,343	1,847	5,670	5,774
98	5,495	5,805	8,554	1,893	5,813	5,923
99+	5,634	5,951	8,766	1,942	5,958	6,069

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,517	2,661	7,839	1,733	5,329	5,139
65	2,517	2,661	3,920	867	2,665	2,569
66	2,517	2,661	3,920	867	2,665	2,569
67	2,517	2,661	3,920	867	2,665	2,569
68	2,546	2,691	3,960	877	2,692	2,655
69	2,604	2,753	4,052	897	2,754	2,768
70	2,673	2,823	4,159	921	2,826	2,872
71	2,753	2,907	4,286	949	2,913	2,973
72	2,839	3,002	4,420	979	3,003	3,074
73	2,930	3,098	4,562	1,009	3,102	3,178
74	3,035	3,205	4,722	1,046	3,206	3,287
75	3,141	3,320	4,888	1,083	3,321	3,391
76	3,248	3,436	5,060	1,121	3,439	3,502
77	3,364	3,555	5,237	1,160	3,557	3,616
78	3,479	3,675	5,415	1,199	3,677	3,738
79	3,587	3,792	5,582	1,235	3,794	3,859
80	3,700	3,909	5,759	1,275	3,916	3,990
81	3,818	4,033	5,942	1,315	4,037	4,116
82	3,932	4,153	6,116	1,355	4,156	4,236
83	4,052	4,279	6,307	1,397	4,286	4,366
84	4,171	4,407	6,490	1,438	4,411	4,494
85	4,321	4,563	6,727	1,489	4,569	4,655
86	4,444	4,696	6,921	1,531	4,703	4,790
87	4,569	4,827	7,117	1,575	4,835	4,927
88	4,700	4,964	7,316	1,621	4,971	5,063
89	4,828	5,103	7,517	1,666	5,109	5,206
90	4,961	5,243	7,727	1,712	5,248	5,344
91	5,097	5,386	7,934	1,756	5,392	5,495
92	5,236	5,532	8,148	1,806	5,537	5,640
93	5,375	5,678	8,367	1,853	5,682	5,791
94	5,513	5,828	8,586	1,901	5,836	5,944
95	5,660	5,979	8,810	1,951	5,987	6,099
96	5,806	6,134	9,039	2,002	6,142	6,254
97	5,957	6,291	9,268	2,052	6,298	6,416
98	6,106	6,448	9,507	2,104	6,457	6,580
99+	6,259	6,612	9,742	2,158	6,619	6,744

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 and Life Insurance Company

Annual Premiums

For Use in: Rest of State

Female Rates

Rates effective 1/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,699	1,796	5,288	1,170	3,594	3,462
65	1,699	1,796	2,644	585	1,797	1,731
66	1,699	1,796	2,644	585	1,797	1,731
67	1,699	1,796	2,644	585	1,797	1,731
68	1,716	1,814	2,674	591	1,817	1,794
69	1,756	1,856	2,734	605	1,857	1,867
70	1,803	1,904	2,808	621	1,905	1,938
71	1,856	1,961	2,891	640	1,965	2,006
72	1,916	2,024	2,982	660	2,025	2,074
73	1,977	2,090	3,078	682	2,092	2,144
74	2,047	2,164	3,185	706	2,165	2,218
75	2,118	2,240	3,297	730	2,241	2,289
76	2,192	2,318	3,412	756	2,320	2,362
77	2,270	2,399	3,534	782	2,400	2,442
78	2,347	2,479	3,654	809	2,481	2,521
79	2,420	2,558	3,766	834	2,560	2,603
80	2,497	2,638	3,885	861	2,641	2,691
81	2,575	2,721	4,009	887	2,723	2,775
82	2,652	2,800	4,128	914	2,805	2,857
83	2,734	2,889	4,254	942	2,891	2,945
84	2,814	2,972	4,379	970	2,975	3,032
85	2,916	3,079	4,539	1,005	3,084	3,141
86	2,999	3,168	4,668	1,034	3,170	3,233
87	3,084	3,257	4,801	1,063	3,262	3,322
88	3,169	3,351	4,936	1,093	3,354	3,415
89	3,258	3,442	5,071	1,124	3,448	3,511
90	3,347	3,537	5,211	1,154	3,539	3,607
91	3,438	3,634	5,354	1,185	3,636	3,707
92	3,531	3,731	5,496	1,218	3,735	3,806
93	3,625	3,830	5,644	1,250	3,834	3,905
94	3,722	3,932	5,793	1,283	3,936	4,010
95	3,818	4,034	5,945	1,317	4,038	4,116
96	3,917	4,141	6,099	1,350	4,144	4,220
97	4,018	4,246	6,254	1,384	4,249	4,329
98	4,119	4,351	6,414	1,419	4,356	4,440
99+	4,223	4,461	6,573	1,455	4,465	4,550

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,887	1,996	5,878	1,300	3,994	3,850
65	1,887	1,996	2,939	650	1,997	1,925
66	1,887	1,996	2,939	650	1,997	1,925
67	1,887	1,996	2,939	650	1,997	1,925
68	1,909	2,017	2,969	657	2,018	1,991
69	1,953	2,061	3,038	672	2,063	2,074
70	2,003	2,117	3,117	690	2,118	2,153
71	2,061	2,179	3,212	711	2,182	2,228
72	2,129	2,249	3,311	734	2,250	2,304
73	2,199	2,322	3,420	757	2,325	2,382
74	2,274	2,402	3,539	784	2,405	2,464
75	2,354	2,487	3,665	812	2,490	2,545
76	2,436	2,575	3,792	840	2,576	2,624
77	2,521	2,665	3,926	869	2,667	2,711
78	2,608	2,754	4,058	899	2,759	2,801
79	2,690	2,843	4,185	926	2,846	2,892
80	2,774	2,932	4,317	956	2,934	2,991
81	2,862	3,023	4,454	986	3,025	3,084
82	2,947	3,112	4,586	1,015	3,116	3,174
83	3,038	3,209	4,727	1,047	3,212	3,272
84	3,127	3,304	4,866	1,078	3,306	3,368
85	3,237	3,422	5,041	1,116	3,427	3,490
86	3,334	3,520	5,188	1,148	3,525	3,589
87	3,427	3,618	5,334	1,181	3,624	3,692
88	3,524	3,722	5,484	1,215	3,726	3,796
89	3,621	3,826	5,635	1,249	3,829	3,900
90	3,721	3,931	5,790	1,283	3,933	4,006
91	3,823	4,037	5,948	1,317	4,042	4,119
92	3,924	4,146	6,107	1,354	4,149	4,228
93	4,028	4,255	6,272	1,389	4,261	4,341
94	4,133	4,370	6,438	1,425	4,373	4,457
95	4,243	4,480	6,605	1,463	4,489	4,573
96	4,352	4,599	6,775	1,501	4,604	4,689
97	4,464	4,716	6,948	1,538	4,721	4,809
98	4,577	4,835	7,125	1,577	4,840	4,933
99+	4,690	4,958	7,304	1,618	4,963	5,055

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)

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

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

Aetna Health and Life Insurance Company

Annual Premiums

For Use in: Rest of State

Male Rates

Rates effective 1/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,954	2,067	6,082	1,346	4,136	3,982
65	1,954	2,067	3,041	673	2,068	1,991
66	1,954	2,067	3,041	673	2,068	1,991
67	1,954	2,067	3,041	673	2,068	1,991
68	1,975	2,086	3,074	681	2,090	2,060
69	2,021	2,134	3,145	696	2,135	2,147
70	2,073	2,191	3,229	714	2,192	2,228
71	2,134	2,255	3,326	737	2,258	2,306
72	2,203	2,327	3,429	759	2,328	2,386
73	2,274	2,401	3,538	783	2,406	2,466
74	2,354	2,487	3,665	812	2,490	2,550
75	2,436	2,575	3,792	840	2,576	2,635
76	2,521	2,664	3,924	869	2,667	2,716
77	2,611	2,760	4,061	900	2,761	2,808
78	2,697	2,850	4,201	930	2,854	2,900
79	2,785	2,941	4,332	959	2,944	2,993
80	2,872	3,035	4,470	990	3,037	3,093
81	2,962	3,128	4,611	1,021	3,133	3,193
82	3,049	3,220	4,748	1,050	3,226	3,285
83	3,145	3,321	4,894	1,083	3,326	3,388
84	3,236	3,419	5,037	1,115	3,422	3,486
85	3,353	3,541	5,218	1,155	3,548	3,613
86	3,449	3,643	5,368	1,188	3,648	3,717
87	3,548	3,746	5,521	1,222	3,752	3,823
88	3,646	3,852	5,676	1,257	3,856	3,929
89	3,747	3,958	5,833	1,292	3,963	4,037
90	3,851	4,069	5,994	1,327	4,071	4,147
91	3,955	4,179	6,156	1,363	4,182	4,263
92	4,060	4,292	6,322	1,400	4,296	4,375
93	4,169	4,406	6,491	1,437	4,411	4,492
94	4,279	4,522	6,663	1,476	4,527	4,613
95	4,392	4,638	6,838	1,514	4,646	4,734
96	4,504	4,761	7,012	1,553	4,765	4,854
97	4,621	4,881	7,192	1,592	4,888	4,978
98	4,737	5,004	7,374	1,632	5,011	5,106
99+	4,857	5,130	7,557	1,674	5,136	5,232

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,170	2,294	6,758	1,494	4,594	4,430
65	2,170	2,294	3,379	747	2,297	2,215
66	2,170	2,294	3,379	747	2,297	2,215
67	2,170	2,294	3,379	747	2,297	2,215
68	2,195	2,320	3,414	756	2,321	2,289
69	2,245	2,373	3,493	773	2,374	2,386
70	2,304	2,434	3,585	794	2,436	2,476
71	2,373	2,506	3,695	818	2,511	2,563
72	2,447	2,588	3,810	844	2,589	2,650
73	2,526	2,671	3,933	870	2,674	2,740
74	2,616	2,763	4,071	902	2,764	2,834
75	2,708	2,862	4,214	934	2,863	2,923
76	2,800	2,962	4,362	966	2,965	3,019
77	2,900	3,065	4,515	1,000	3,066	3,117
78	2,999	3,168	4,668	1,034	3,170	3,222
79	3,092	3,269	4,812	1,065	3,271	3,327
80	3,190	3,370	4,965	1,099	3,376	3,440
81	3,291	3,477	5,122	1,134	3,480	3,548
82	3,390	3,580	5,272	1,168	3,583	3,652
83	3,493	3,689	5,437	1,204	3,695	3,764
84	3,596	3,799	5,595	1,240	3,803	3,874
85	3,725	3,934	5,799	1,284	3,939	4,013
86	3,831	4,048	5,966	1,320	4,054	4,129
87	3,939	4,161	6,135	1,358	4,168	4,247
88	4,052	4,279	6,307	1,397	4,285	4,365
89	4,162	4,399	6,480	1,436	4,404	4,488
90	4,277	4,520	6,661	1,476	4,524	4,607
91	4,394	4,643	6,840	1,514	4,648	4,737
92	4,514	4,769	7,024	1,557	4,773	4,862
93	4,634	4,895	7,213	1,597	4,898	4,992
94	4,753	5,024	7,402	1,639	5,031	5,124
95	4,879	5,154	7,595	1,682	5,161	5,258
96	5,005	5,288	7,792	1,726	5,295	5,391
97	5,135	5,423	7,990	1,769	5,429	5,531
98	5,264	5,559	8,196	1,814	5,566	5,672
99+	5,396	5,700	8,398	1,860	5,706	5,814

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 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 $1,676	$0	$1,676 (Part A Deductible)
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	$0	Up to $209.50 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 $257 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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	$0	Up to $209.50 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 B

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

*Once you have been billed $257 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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 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 $257 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 $257 of Medicare-Approved amounts*	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$257 (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 $2,870 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,870. 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 $2,870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,870 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 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 $257 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 $2,870 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,870. 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 $2,870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,870 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 $257 of Medicare-Approved amounts*	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$257 (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 $2,870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,870 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $257 of Medicare-Approved amounts*	$0	$257 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,870 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 $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 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 $257 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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 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 $257 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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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