Outline of coverage

Medicare Supplement Insurance

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

Oklahoma

Underwritten by

Aetna Health Insurance Company

AetnaSeniorProducts.com

AHCMS05285OK

Rates effective: 02/2024 A

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and High Deductible F.

Note: A ✓ means 100% of the benefit is paid.

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

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

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

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

Aetna Health Insurance Company
Annual premiums
For use in ZIP Codes: 730-731, 741
Female rates

Rates effective 2/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,839	-	-	-	-	-
65	1,839	1,742	2,104	594	1,696	1,172
66	1,840	1,744	2,106	595	1,697	1,173
67	1,841	1,745	2,108	596	1,698	1,174
68	1,862	1,765	2,131	603	1,717	1,217
69	1,905	1,805	2,179	616	1,756	1,266
70	1,954	1,852	2,237	632	1,803	1,314
71	2,013	1,909	2,304	652	1,858	1,361
72	2,076	1,966	2,376	672	1,914	1,408
73	2,143	2,030	2,454	693	1,976	1,455
74	2,220	2,102	2,540	718	2,046	1,503
75	2,298	2,176	2,630	742	2,119	1,552
76	2,377	2,252	2,722	769	2,192	1,603
77	2,461	2,332	2,816	795	2,268	1,656
78	2,543	2,411	2,913	823	2,348	1,712
79	2,623	2,485	3,005	848	2,419	1,767
80	2,706	2,564	3,097	876	2,497	1,825
81	2,792	2,646	3,194	903	2,575	1,884
82	2,875	2,723	3,292	930	2,652	1,940
83	2,964	2,808	3,391	958	2,733	1,999
84	3,049	2,889	3,493	987	2,812	2,056
85	3,161	2,995	3,616	1,023	2,915	2,132
86	3,251	3,081	3,721	1,052	2,999	2,193
87	3,343	3,168	3,824	1,081	3,083	2,254
88	3,438	3,254	3,934	1,111	3,169	2,317
89	3,531	3,346	4,042	1,143	3,261	2,382
90	3,630	3,439	4,154	1,174	3,348	2,447
91	3,728	3,531	4,267	1,205	3,438	2,514
92	3,826	3,629	4,380	1,238	3,533	2,583
93	3,931	3,725	4,498	1,272	3,626	2,650
94	4,033	3,820	4,618	1,305	3,720	2,722
95	4,140	3,924	4,738	1,339	3,819	2,794
96	4,247	4,022	4,860	1,373	3,915	2,864
97	4,356	4,126	4,984	1,409	4,018	2,938
98	4,465	4,229	5,111	1,444	4,118	3,012
99+	4,576	4,336	5,238	1,480	4,221	3,088

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,043	-	-	-	-	-
65	2,043	1,938	2,340	660	1,886	1,302
66	2,044	1,939	2,341	661	1,887	1,304
67	2,046	1,940	2,343	662	1,888	1,305
68	2,069	1,959	2,367	670	1,907	1,351
69	2,115	2,004	2,422	684	1,953	1,408
70	2,170	2,058	2,485	704	2,002	1,461
71	2,237	2,121	2,560	724	2,064	1,513
72	2,307	2,185	2,642	746	2,127	1,564
73	2,382	2,257	2,727	771	2,196	1,617
74	2,467	2,336	2,822	797	2,276	1,672
75	2,553	2,417	2,920	825	2,352	1,725
76	2,643	2,501	3,023	854	2,435	1,780
77	2,735	2,591	3,129	885	2,522	1,840
78	2,826	2,677	3,236	914	2,608	1,902
79	2,915	2,760	3,335	943	2,686	1,963
80	3,008	2,848	3,443	973	2,775	2,028
81	3,102	2,940	3,549	1,003	2,862	2,093
82	3,192	3,025	3,655	1,032	2,946	2,156
83	3,294	3,118	3,769	1,065	3,034	2,222
84	3,388	3,211	3,878	1,097	3,128	2,287
85	3,511	3,326	4,019	1,136	3,238	2,368
86	3,610	3,425	4,136	1,169	3,332	2,435
87	3,716	3,519	4,251	1,201	3,426	2,506
88	3,818	3,616	4,371	1,234	3,520	2,574
89	3,925	3,718	4,494	1,270	3,620	2,646
90	4,032	3,819	4,615	1,305	3,717	2,721
91	4,142	3,925	4,741	1,339	3,820	2,796
92	4,254	4,031	4,870	1,375	3,923	2,870
93	4,366	4,139	4,998	1,414	4,029	2,945
94	4,482	4,247	5,130	1,449	4,133	3,023
95	4,599	4,358	5,264	1,487	4,242	3,101
96	4,719	4,469	5,400	1,526	4,350	3,183
97	4,838	4,585	5,539	1,565	4,461	3,265
98	4,960	4,698	5,678	1,605	4,578	3,346
99+	5,085	4,817	5,820	1,644	4,689	3,430

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

To calculate a 7% household discount:

Annual premium **x** modal factor **= modal premium** (round to nearest whole cent)
Modal premium **x** .93 **= discounted premium**

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

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

Aetna Health Insurance Company
Annual premiums
For use in ZIP Codes: 730-731, 734
Male rates

Rates effective 2/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,115	-	-	-	-	-
65	2,115	2,003	2,420	683	1,950	1,349
66	2,117	2,004	2,422	684	1,953	1,350
67	2,118	2,007	2,424	685	1,954	1,351
68	2,139	2,028	2,449	692	1,973	1,399
69	2,189	2,075	2,508	708	2,021	1,456
70	2,246	2,130	2,574	727	2,075	1,512
71	2,316	2,195	2,650	750	2,135	1,565
72	2,388	2,260	2,733	773	2,202	1,618
73	2,466	2,336	2,822	797	2,274	1,673
74	2,553	2,417	2,920	826	2,353	1,729
75	2,643	2,501	3,024	854	2,435	1,785
76	2,735	2,590	3,129	885	2,522	1,842
77	2,830	2,681	3,238	915	2,609	1,904
78	2,928	2,772	3,351	946	2,699	1,969
79	3,019	2,859	3,454	975	2,783	2,034
80	3,113	2,949	3,563	1,007	2,872	2,100
81	3,211	3,040	3,674	1,040	2,959	2,166
82	3,306	3,130	3,785	1,068	3,050	2,230
83	3,405	3,229	3,899	1,103	3,143	2,298
84	3,508	3,322	4,015	1,135	3,232	2,365
85	3,636	3,444	4,161	1,176	3,352	2,453
86	3,737	3,541	4,281	1,210	3,446	2,523
87	3,847	3,643	4,398	1,243	3,547	2,593
88	3,952	3,743	4,524	1,278	3,644	2,667
89	4,063	3,849	4,648	1,314	3,749	2,740
90	4,172	3,953	4,778	1,351	3,848	2,816
91	4,288	4,063	4,908	1,387	3,955	2,891
92	4,404	4,171	5,040	1,423	4,059	2,969
93	4,519	4,283	5,173	1,463	4,170	3,050
94	4,639	4,395	5,309	1,500	4,278	3,130
95	4,760	4,511	5,449	1,540	4,390	3,211
96	4,884	4,627	5,589	1,579	4,503	3,294
97	5,009	4,744	5,733	1,620	4,618	3,379
98	5,133	4,863	5,877	1,661	4,737	3,464
99+	5,263	4,985	6,025	1,702	4,852	3,550

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,350	-	-	-	-	-
65	2,350	2,228	2,690	759	2,169	1,499
66	2,351	2,229	2,691	760	2,170	1,500
67	2,352	2,230	2,694	761	2,171	1,501
68	2,378	2,254	2,723	770	2,195	1,553
69	2,433	2,305	2,785	786	2,244	1,618
70	2,497	2,366	2,859	809	2,303	1,680
71	2,574	2,438	2,945	833	2,374	1,742
72	2,652	2,512	3,037	859	2,444	1,799
73	2,740	2,597	3,137	887	2,526	1,858
74	2,838	2,686	3,245	918	2,615	1,922
75	2,938	2,779	3,360	948	2,706	1,983
76	3,038	2,876	3,475	982	2,800	2,047
77	3,145	2,978	3,599	1,016	2,899	2,115
78	3,251	3,081	3,721	1,051	3,000	2,186
79	3,353	3,174	3,835	1,084	3,091	2,258
80	3,458	3,277	3,957	1,119	3,194	2,334
81	3,568	3,380	4,082	1,155	3,290	2,406
82	3,671	3,478	4,206	1,188	3,387	2,479
83	3,789	3,588	4,333	1,225	3,492	2,554
84	3,897	3,689	4,461	1,260	3,594	2,629
85	4,037	3,824	4,622	1,307	3,724	2,725
86	4,154	3,936	4,755	1,344	3,832	2,802
87	4,272	4,046	4,888	1,381	3,941	2,881
88	4,391	4,161	5,025	1,420	4,050	2,960
89	4,512	4,276	5,166	1,461	4,164	3,046
90	4,638	4,393	5,307	1,500	4,276	3,129
91	4,763	4,512	5,451	1,540	4,391	3,214
92	4,891	4,636	5,599	1,582	4,512	3,298
93	5,023	4,758	5,748	1,626	4,631	3,388
94	5,156	4,884	5,900	1,668	4,754	3,477
95	5,290	5,011	6,053	1,711	4,879	3,568
96	5,428	5,141	6,210	1,755	5,004	3,659
97	5,564	5,271	6,369	1,800	5,131	3,754
98	5,705	5,404	6,531	1,846	5,263	3,849
99+	5,847	5,539	6,693	1,890	5,394	3,944

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

To calculate a 7% household discount:

Annual premium **x** modal factor **= modal premium** (round to nearest whole cent)
Modal premium **x** .93 **= discounted premium**

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

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

Aetna Health Insurance Company
Annual premiums
For use in: Rest of State
Female rates

Rates effective 2/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,703	-	-	-	-	-
65	1,703	1,613	1,948	550	1,570	1,085
66	1,704	1,615	1,950	551	1,571	1,086
67	1,705	1,616	1,952	552	1,572	1,087
68	1,724	1,634	1,973	558	1,590	1,127
69	1,764	1,671	2,018	570	1,626	1,172
70	1,809	1,715	2,071	585	1,669	1,217
71	1,864	1,768	2,133	604	1,720	1,260
72	1,922	1,820	2,200	622	1,772	1,304
73	1,984	1,880	2,272	642	1,830	1,347
74	2,056	1,946	2,352	665	1,894	1,392
75	2,128	2,015	2,435	687	1,962	1,437
76	2,201	2,085	2,520	712	2,030	1,484
77	2,279	2,159	2,607	736	2,100	1,533
78	2,355	2,232	2,697	762	2,174	1,585
79	2,429	2,301	2,782	785	2,240	1,636
80	2,506	2,374	2,868	811	2,312	1,690
81	2,585	2,450	2,957	836	2,384	1,744
82	2,662	2,521	3,048	861	2,456	1,796
83	2,744	2,600	3,140	887	2,531	1,851
84	2,823	2,675	3,234	914	2,604	1,904
85	2,927	2,773	3,348	947	2,699	1,974
86	3,010	2,853	3,445	974	2,777	2,031
87	3,095	2,933	3,541	1,001	2,855	2,087
88	3,183	3,013	3,643	1,029	2,934	2,145
89	3,269	3,098	3,743	1,058	3,019	2,206
90	3,361	3,184	3,846	1,087	3,100	2,266
91	3,452	3,269	3,951	1,116	3,183	2,328
92	3,543	3,360	4,056	1,146	3,271	2,392
93	3,640	3,449	4,165	1,178	3,357	2,454
94	3,734	3,537	4,276	1,208	3,444	2,520
95	3,833	3,633	4,387	1,240	3,536	2,587
96	3,932	3,724	4,500	1,271	3,625	2,652
97	4,033	3,820	4,615	1,305	3,720	2,720
98	4,134	3,916	4,732	1,337	3,813	2,789
99+	4,237	4,015	4,850	1,370	3,908	2,859

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,892	-	-	-	-	-
65	1,892	1,794	2,167	611	1,746	1,206
66	1,893	1,795	2,168	612	1,747	1,207
67	1,894	1,796	2,169	613	1,748	1,208
68	1,916	1,814	2,192	620	1,766	1,251
69	1,958	1,856	2,243	633	1,808	1,304
70	2,009	1,906	2,301	652	1,854	1,353
71	2,071	1,964	2,370	670	1,911	1,401
72	2,136	2,023	2,446	691	1,969	1,448
73	2,206	2,090	2,525	714	2,033	1,497
74	2,284	2,163	2,613	738	2,107	1,548
75	2,364	2,238	2,704	764	2,178	1,597
76	2,447	2,316	2,799	791	2,255	1,648
77	2,532	2,399	2,897	819	2,335	1,704
78	2,617	2,479	2,996	846	2,415	1,761
79	2,699	2,556	3,088	873	2,487	1,818
80	2,785	2,637	3,188	901	2,569	1,878
81	2,872	2,722	3,286	929	2,650	1,938
82	2,956	2,801	3,384	956	2,728	1,996
83	3,050	2,887	3,490	986	2,809	2,057
84	3,137	2,973	3,591	1,016	2,896	2,118
85	3,251	3,080	3,721	1,052	2,998	2,193
86	3,343	3,171	3,830	1,082	3,085	2,255
87	3,441	3,258	3,936	1,112	3,172	2,320
88	3,535	3,348	4,047	1,143	3,259	2,383
89	3,634	3,443	4,161	1,176	3,352	2,450
90	3,733	3,536	4,273	1,208	3,442	2,519
91	3,835	3,634	4,390	1,240	3,537	2,589
92	3,939	3,732	4,509	1,273	3,632	2,657
93	4,043	3,832	4,628	1,309	3,731	2,727
94	4,150	3,932	4,750	1,342	3,827	2,799
95	4,258	4,035	4,874	1,377	3,928	2,871
96	4,369	4,138	5,000	1,413	4,028	2,947
97	4,480	4,245	5,129	1,449	4,131	3,023
98	4,593	4,350	5,257	1,486	4,239	3,098
99+	4,708	4,460	5,389	1,522	4,342	3,176

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

To calculate a 7% household discount:

Annual premium **x** modal factor **= modal premium** (round to nearest whole cent)
Modal premium **x** .93 **= discounted premium**

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

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

Aetna Health Insurance Company

Annual premiums

For use in: Rest of State

Male rates

Rates effective 2/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,958	-	-	-	-	-
65	1,958	1,855	2,241	632	1,806	1,249
66	1,960	1,856	2,243	633	1,808	1,250
67	1,961	1,858	2,244	634	1,809	1,251
68	1,981	1,878	2,268	641	1,827	1,295
69	2,027	1,921	2,322	656	1,871	1,348
70	2,080	1,972	2,383	673	1,921	1,400
71	2,144	2,032	2,454	694	1,977	1,449
72	2,211	2,093	2,531	716	2,039	1,498
73	2,283	2,163	2,613	738	2,106	1,549
74	2,364	2,238	2,704	765	2,179	1,601
75	2,447	2,316	2,800	791	2,255	1,653
76	2,532	2,398	2,897	819	2,335	1,706
77	2,620	2,482	2,998	847	2,416	1,763
78	2,711	2,567	3,103	876	2,499	1,823
79	2,795	2,647	3,198	903	2,577	1,883
80	2,882	2,731	3,299	932	2,659	1,944
81	2,973	2,815	3,402	963	2,740	2,006
82	3,061	2,898	3,505	989	2,824	2,065
83	3,153	2,990	3,610	1,021	2,910	2,128
84	3,248	3,076	3,718	1,051	2,993	2,190
85	3,367	3,189	3,853	1,089	3,104	2,271
86	3,460	3,279	3,964	1,120	3,191	2,336
87	3,562	3,373	4,072	1,151	3,284	2,401
88	3,659	3,466	4,189	1,183	3,374	2,469
89	3,762	3,564	4,304	1,217	3,471	2,537
90	3,863	3,660	4,424	1,251	3,563	2,607
91	3,970	3,762	4,544	1,284	3,662	2,677
92	4,078	3,862	4,667	1,318	3,758	2,749
93	4,184	3,966	4,790	1,355	3,861	2,824
94	4,295	4,069	4,916	1,389	3,961	2,898
95	4,407	4,177	5,045	1,426	4,065	2,973
96	4,522	4,284	5,175	1,462	4,169	3,050
97	4,638	4,393	5,308	1,500	4,276	3,129
98	4,753	4,503	5,442	1,538	4,386	3,207
99+	4,873	4,616	5,579	1,576	4,493	3,287

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,176	-	-	-	-	-
65	2,176	2,063	2,491	703	2,008	1,388
66	2,177	2,064	2,492	704	2,009	1,389
67	2,178	2,065	2,494	705	2,010	1,390
68	2,202	2,087	2,521	713	2,032	1,438
69	2,253	2,134	2,579	728	2,078	1,498
70	2,312	2,191	2,647	749	2,132	1,556
71	2,383	2,257	2,727	771	2,198	1,613
72	2,456	2,326	2,812	795	2,263	1,666
73	2,537	2,405	2,905	821	2,339	1,720
74	2,628	2,487	3,005	850	2,421	1,780
75	2,720	2,573	3,111	878	2,506	1,836
76	2,813	2,663	3,218	909	2,593	1,895
77	2,912	2,757	3,332	941	2,684	1,958
78	3,010	2,853	3,445	973	2,778	2,024
79	3,105	2,939	3,551	1,004	2,862	2,091
80	3,202	3,034	3,664	1,036	2,957	2,161
81	3,304	3,130	3,780	1,069	3,046	2,228
82	3,399	3,220	3,894	1,100	3,136	2,295
83	3,508	3,322	4,012	1,134	3,233	2,365
84	3,608	3,416	4,131	1,167	3,328	2,434
85	3,738	3,541	4,280	1,210	3,448	2,523
86	3,846	3,644	4,403	1,244	3,548	2,594
87	3,956	3,746	4,526	1,279	3,649	2,668
88	4,066	3,853	4,653	1,315	3,750	2,741
89	4,178	3,959	4,783	1,353	3,856	2,820
90	4,294	4,068	4,914	1,389	3,959	2,897
91	4,410	4,178	5,047	1,426	4,066	2,976
92	4,529	4,293	5,184	1,465	4,178	3,054
93	4,651	4,406	5,322	1,506	4,288	3,137
94	4,774	4,522	5,463	1,544	4,402	3,219
95	4,898	4,640	5,605	1,584	4,518	3,304
96	5,026	4,760	5,750	1,625	4,633	3,388
97	5,152	4,881	5,897	1,667	4,751	3,476
98	5,282	5,004	6,047	1,709	4,873	3,564
99+	5,414	5,129	6,197	1,750	4,994	3,652

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

To calculate a 7% household discount:

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

Modal premium **x** .93 **= discounted premium**

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

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

PREMIUM INFORMATION

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

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

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

HOUSEHOLD DISCOUNT

In order to be eligible for the Household discount under an Aetna Health Insurance Company Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently must currently be covered by an Aetna Company Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (b) someone with whom you are in a civil union partnership; and (c) someone with whom you have continuously resided for the past 12 months. The household discount will only be applicable if a policy for each applicant is issued. The discounted rates will be 7 percent lower than the individual rates and will apply as long as both policies remain in force.

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

The policy may not cover all of your medical costs.

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

PLAN A

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

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

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

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

***Deductible amounts announced annually by CMS

PLAN A

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

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

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

PARTS A & B

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

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

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

***Deductible amounts announced annually by CMS

PLAN B

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

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

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

PARTS A & B

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

PLAN F

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

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

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

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

***Deductible amounts announced annually by CMS

PLAN F

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

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

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

PARTS A & B

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

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

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

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

***Deductible amounts announced annually by CMS

HIGH DEDUCTIBLE PLAN F

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

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

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

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

***Deductible amounts announced annually by CMS

HIGH DEDUCTIBLE PLAN F

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

***Deductible amounts announced annually by CMS

PLAN G

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

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

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

PARTS A & B

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

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

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

***Deductible amounts announced annually by CMS

PLAN N

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

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

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

***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 $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

***Deductible amounts announced annually by CMS