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: 02/2025 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 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 Insurance Company
Annual premiums
For use in ZIP Codes: 730-731, 741
Female rates

Rates effective 2/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,208	-	-	-	-	-
65	2,208	2,091	2,525	594	2,035	1,406
66	2,209	2,093	2,527	595	2,036	1,407
67	2,210	2,094	2,529	596	2,037	1,408
68	2,235	2,118	2,557	603	2,061	1,460
69	2,286	2,165	2,616	616	2,107	1,518
70	2,345	2,223	2,684	632	2,163	1,577
71	2,416	2,292	2,765	652	2,229	1,633
72	2,490	2,359	2,851	672	2,296	1,690
73	2,571	2,436	2,944	693	2,372	1,745
74	2,664	2,522	3,048	718	2,455	1,804
75	2,758	2,611	3,156	742	2,542	1,862
76	2,852	2,702	3,266	769	2,631	1,923
77	2,954	2,798	3,378	795	2,722	1,987
78	3,052	2,892	3,495	823	2,818	2,054
79	3,148	2,982	3,605	848	2,903	2,120
80	3,248	3,077	3,717	876	2,996	2,190
81	3,350	3,175	3,832	903	3,090	2,260
82	3,450	3,267	3,951	930	3,183	2,327
83	3,556	3,370	4,069	958	3,280	2,399
84	3,659	3,467	4,191	987	3,375	2,468
85	3,793	3,594	4,339	1,023	3,498	2,559
86	3,901	3,698	4,465	1,052	3,599	2,632
87	4,011	3,802	4,589	1,081	3,700	2,704
88	4,126	3,905	4,722	1,111	3,803	2,780
89	4,237	4,015	4,851	1,143	3,913	2,859
90	4,356	4,127	4,984	1,174	4,018	2,937
91	4,473	4,237	5,120	1,205	4,126	3,018
92	4,592	4,355	5,256	1,238	4,239	3,100
93	4,717	4,470	5,398	1,272	4,350	3,181
94	4,839	4,584	5,541	1,305	4,464	3,266
95	4,968	4,709	5,685	1,339	4,582	3,352
96	5,095	4,827	5,832	1,373	4,698	3,437
97	5,227	4,951	5,981	1,409	4,821	3,525
98	5,358	5,075	6,132	1,444	4,942	3,615
99+	5,491	5,203	6,286	1,480	5,065	3,705

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,452	-	-	-	-	-
65	2,452	2,325	2,808	660	2,263	1,563
66	2,454	2,326	2,810	661	2,264	1,564
67	2,455	2,327	2,811	662	2,266	1,566
68	2,483	2,351	2,840	670	2,289	1,621
69	2,538	2,405	2,907	684	2,344	1,690
70	2,604	2,470	2,982	704	2,403	1,754
71	2,684	2,546	3,072	724	2,476	1,815
72	2,768	2,622	3,170	746	2,552	1,877
73	2,859	2,709	3,272	771	2,635	1,940
74	2,960	2,804	3,387	797	2,730	2,007
75	3,064	2,901	3,505	825	2,823	2,069
76	3,171	3,001	3,628	854	2,922	2,136
77	3,281	3,109	3,754	885	3,026	2,209
78	3,391	3,213	3,883	914	3,130	2,282
79	3,498	3,312	4,002	943	3,223	2,357
80	3,609	3,417	4,132	973	3,330	2,434
81	3,722	3,527	4,258	1,003	3,434	2,512
82	3,831	3,630	4,386	1,032	3,536	2,587
83	3,953	3,741	4,523	1,065	3,641	2,665
84	4,065	3,853	4,654	1,097	3,753	2,745
85	4,213	3,992	4,822	1,136	3,886	2,843
86	4,333	4,109	4,964	1,169	3,998	2,922
87	4,459	4,223	5,101	1,201	4,110	3,007
88	4,581	4,339	5,244	1,234	4,224	3,089
89	4,710	4,463	5,392	1,270	4,344	3,175
90	4,838	4,582	5,538	1,305	4,460	3,265
91	4,970	4,710	5,689	1,339	4,584	3,356
92	5,105	4,836	5,844	1,375	4,707	3,443
93	5,240	4,966	5,998	1,414	4,835	3,534
94	5,378	5,095	6,156	1,449	4,959	3,628
95	5,519	5,229	6,317	1,487	5,091	3,721
96	5,662	5,363	6,480	1,526	5,221	3,819
97	5,806	5,502	6,647	1,565	5,354	3,918
98	5,953	5,638	6,813	1,605	5,494	4,015
99+	6,102	5,780	6,984	1,644	5,627	4,116

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 2/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,538	-	-	-	-	-
65	2,538	2,404	2,904	683	2,340	1,619
66	2,540	2,405	2,907	684	2,344	1,620
67	2,541	2,408	2,908	685	2,345	1,621
68	2,567	2,434	2,940	692	2,367	1,678
69	2,627	2,489	3,009	708	2,425	1,747
70	2,696	2,555	3,089	727	2,489	1,814
71	2,779	2,633	3,181	750	2,562	1,878
72	2,865	2,713	3,280	773	2,643	1,942
73	2,959	2,804	3,387	797	2,729	2,008
74	3,064	2,901	3,505	826	2,824	2,075
75	3,171	3,001	3,629	854	2,922	2,143
76	3,281	3,108	3,754	885	3,026	2,211
77	3,396	3,216	3,886	915	3,131	2,285
78	3,513	3,326	4,022	946	3,239	2,363
79	3,622	3,430	4,145	975	3,339	2,441
80	3,735	3,539	4,276	1,007	3,446	2,520
81	3,853	3,648	4,409	1,040	3,551	2,600
82	3,967	3,756	4,542	1,068	3,660	2,676
83	4,087	3,875	4,679	1,103	3,771	2,758
84	4,210	3,986	4,819	1,135	3,879	2,838
85	4,363	4,133	4,994	1,176	4,023	2,943
86	4,484	4,250	5,138	1,210	4,135	3,027
87	4,616	4,372	5,277	1,243	4,256	3,111
88	4,742	4,492	5,429	1,278	4,373	3,200
89	4,875	4,619	5,578	1,314	4,498	3,288
90	5,007	4,743	5,734	1,351	4,618	3,378
91	5,145	4,875	5,889	1,387	4,746	3,469
92	5,286	5,005	6,048	1,423	4,871	3,563
93	5,423	5,140	6,208	1,463	5,004	3,660
94	5,566	5,274	6,371	1,500	5,133	3,756
95	5,711	5,413	6,538	1,540	5,268	3,853
96	5,860	5,552	6,707	1,579	5,403	3,953
97	6,011	5,694	6,880	1,620	5,541	4,055
98	6,160	5,836	7,052	1,661	5,684	4,156
99+	6,316	5,982	7,231	1,702	5,823	4,260

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,820	-	-	-	-	-
65	2,820	2,674	3,228	759	2,603	1,799
66	2,821	2,675	3,229	760	2,604	1,800
67	2,823	2,676	3,232	761	2,605	1,801
68	2,853	2,704	3,267	770	2,633	1,864
69	2,920	2,766	3,343	786	2,694	1,942
70	2,996	2,839	3,430	809	2,763	2,016
71	3,089	2,925	3,534	833	2,849	2,091
72	3,183	3,014	3,644	859	2,933	2,159
73	3,288	3,117	3,765	887	3,032	2,229
74	3,406	3,223	3,894	918	3,137	2,307
75	3,525	3,335	4,032	948	3,248	2,379
76	3,646	3,452	4,171	982	3,361	2,456
77	3,774	3,573	4,318	1,016	3,479	2,538
78	3,901	3,698	4,465	1,051	3,601	2,623
79	4,024	3,809	4,602	1,084	3,709	2,710
80	4,149	3,932	4,749	1,119	3,832	2,800
81	4,282	4,056	4,899	1,155	3,947	2,888
82	4,405	4,173	5,047	1,188	4,064	2,974
83	4,547	4,305	5,199	1,225	4,190	3,065
84	4,676	4,427	5,354	1,260	4,314	3,155
85	4,845	4,589	5,547	1,307	4,469	3,270
86	4,984	4,723	5,707	1,344	4,599	3,362
87	5,127	4,855	5,865	1,381	4,729	3,458
88	5,269	4,994	6,031	1,420	4,860	3,552
89	5,415	5,131	6,199	1,461	4,997	3,655
90	5,565	5,273	6,369	1,500	5,131	3,754
91	5,715	5,415	6,540	1,540	5,269	3,857
92	5,870	5,564	6,719	1,582	5,415	3,958
93	6,027	5,710	6,897	1,626	5,558	4,065
94	6,187	5,860	7,080	1,668	5,705	4,172
95	6,348	6,013	7,264	1,711	5,856	4,282
96	6,513	6,169	7,452	1,755	6,005	4,391
97	6,677	6,326	7,642	1,800	6,157	4,505
98	6,845	6,485	7,836	1,846	6,316	4,619
99+	7,017	6,647	8,031	1,890	6,472	4,733

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 2/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,044	-	-	-	-	-
65	2,044	1,936	2,338	550	1,884	1,302
66	2,045	1,938	2,340	551	1,885	1,303
67	2,046	1,939	2,342	552	1,886	1,304
68	2,069	1,961	2,368	558	1,908	1,352
69	2,117	2,005	2,422	570	1,951	1,406
70	2,171	2,058	2,485	585	2,003	1,460
71	2,237	2,122	2,560	604	2,064	1,512
72	2,306	2,184	2,640	622	2,126	1,565
73	2,381	2,256	2,726	642	2,196	1,616
74	2,467	2,335	2,822	665	2,273	1,670
75	2,554	2,418	2,922	687	2,354	1,724
76	2,641	2,502	3,024	712	2,436	1,781
77	2,735	2,591	3,128	736	2,520	1,840
78	2,826	2,678	3,236	762	2,609	1,902
79	2,915	2,761	3,338	785	2,688	1,963
80	3,007	2,849	3,442	811	2,774	2,028
81	3,102	2,940	3,548	836	2,861	2,093
82	3,194	3,025	3,658	861	2,947	2,155
83	3,293	3,120	3,768	887	3,037	2,221
84	3,388	3,210	3,881	914	3,125	2,285
85	3,512	3,328	4,018	947	3,239	2,369
86	3,612	3,424	4,134	974	3,332	2,437
87	3,714	3,520	4,249	1,001	3,426	2,504
88	3,820	3,616	4,372	1,029	3,521	2,574
89	3,923	3,718	4,492	1,058	3,623	2,647
90	4,033	3,821	4,615	1,087	3,720	2,719
91	4,142	3,923	4,741	1,116	3,820	2,794
92	4,252	4,032	4,867	1,146	3,925	2,870
93	4,368	4,139	4,998	1,178	4,028	2,945
94	4,481	4,244	5,131	1,208	4,133	3,024
95	4,600	4,360	5,264	1,240	4,243	3,104
96	4,718	4,469	5,400	1,271	4,350	3,182
97	4,840	4,584	5,538	1,305	4,464	3,264
98	4,961	4,699	5,678	1,337	4,576	3,347
99+	5,084	4,818	5,820	1,370	4,690	3,431

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,270	-	-	-	-	-
65	2,270	2,153	2,600	611	2,095	1,447
66	2,272	2,154	2,602	612	2,096	1,448
67	2,273	2,155	2,603	613	2,098	1,450
68	2,299	2,177	2,630	620	2,119	1,501
69	2,350	2,227	2,692	633	2,170	1,565
70	2,411	2,287	2,761	652	2,225	1,624
71	2,485	2,357	2,844	670	2,293	1,681
72	2,563	2,428	2,935	691	2,363	1,738
73	2,647	2,508	3,030	714	2,440	1,796
74	2,741	2,596	3,136	738	2,528	1,858
75	2,837	2,686	3,245	764	2,614	1,916
76	2,936	2,779	3,359	791	2,706	1,978
77	3,038	2,879	3,476	819	2,802	2,045
78	3,140	2,975	3,595	846	2,898	2,113
79	3,239	3,067	3,706	873	2,984	2,182
80	3,342	3,164	3,826	901	3,083	2,254
81	3,446	3,266	3,943	929	3,180	2,326
82	3,547	3,361	4,061	956	3,274	2,395
83	3,660	3,464	4,188	986	3,371	2,468
84	3,764	3,568	4,309	1,016	3,475	2,542
85	3,901	3,696	4,465	1,052	3,598	2,632
86	4,012	3,805	4,596	1,082	3,702	2,706
87	4,129	3,910	4,723	1,112	3,806	2,784
88	4,242	4,018	4,856	1,143	3,911	2,860
89	4,361	4,132	4,993	1,176	4,022	2,940
90	4,480	4,243	5,128	1,208	4,130	3,023
91	4,602	4,361	5,268	1,240	4,244	3,107
92	4,727	4,478	5,411	1,273	4,358	3,188
93	4,852	4,598	5,554	1,309	4,477	3,272
94	4,980	4,718	5,700	1,342	4,592	3,359
95	5,110	4,842	5,849	1,377	4,714	3,445
96	5,243	4,966	6,000	1,413	4,834	3,536
97	5,376	5,094	6,155	1,449	4,957	3,628
98	5,512	5,220	6,308	1,486	5,087	3,718
99+	5,650	5,352	6,467	1,522	5,210	3,811

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

To calculate a 7% household discount:

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

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

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

Aetna Health Insurance Company

Annual premiums

For use in: Rest of State

Male rates

Rates effective 2/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,350	-	-	-	-	-
65	2,350	2,226	2,689	632	2,167	1,499
66	2,352	2,227	2,692	633	2,170	1,500
67	2,353	2,230	2,693	634	2,171	1,501
68	2,377	2,254	2,722	641	2,192	1,554
69	2,432	2,305	2,786	656	2,245	1,618
70	2,496	2,366	2,860	673	2,305	1,680
71	2,573	2,438	2,945	694	2,372	1,739
72	2,653	2,512	3,037	716	2,447	1,798
73	2,740	2,596	3,136	738	2,527	1,859
74	2,837	2,686	3,245	765	2,615	1,921
75	2,936	2,779	3,360	791	2,706	1,984
76	3,038	2,878	3,476	819	2,802	2,047
77	3,144	2,978	3,598	847	2,899	2,116
78	3,253	3,080	3,724	876	2,999	2,188
79	3,354	3,176	3,838	903	3,092	2,260
80	3,458	3,277	3,959	932	3,191	2,333
81	3,568	3,378	4,082	963	3,288	2,407
82	3,673	3,478	4,206	989	3,389	2,478
83	3,784	3,588	4,332	1,021	3,492	2,554
84	3,898	3,691	4,462	1,051	3,592	2,628
85	4,040	3,827	4,624	1,089	3,725	2,725
86	4,152	3,935	4,757	1,120	3,829	2,803
87	4,274	4,048	4,886	1,151	3,941	2,881
88	4,391	4,159	5,027	1,183	4,049	2,963
89	4,514	4,277	5,165	1,217	4,165	3,044
90	4,636	4,392	5,309	1,251	4,276	3,128
91	4,764	4,514	5,453	1,284	4,394	3,212
92	4,894	4,634	5,600	1,318	4,510	3,299
93	5,021	4,759	5,748	1,355	4,633	3,389
94	5,154	4,883	5,899	1,389	4,753	3,478
95	5,288	5,012	6,054	1,426	4,878	3,568
96	5,426	5,141	6,210	1,462	5,003	3,660
97	5,566	5,272	6,370	1,500	5,131	3,755
98	5,704	5,404	6,530	1,538	5,263	3,848
99+	5,848	5,539	6,695	1,576	5,392	3,944

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,611	-	-	-	-	-
65	2,611	2,476	2,989	703	2,410	1,666
66	2,612	2,477	2,990	704	2,411	1,667
67	2,614	2,478	2,993	705	2,412	1,668
68	2,642	2,504	3,025	713	2,438	1,726
69	2,704	2,561	3,095	728	2,494	1,798
70	2,774	2,629	3,176	749	2,558	1,867
71	2,860	2,708	3,272	771	2,638	1,936
72	2,947	2,791	3,374	795	2,716	1,999
73	3,044	2,886	3,486	821	2,807	2,064
74	3,154	2,984	3,606	850	2,905	2,136
75	3,264	3,088	3,733	878	3,007	2,203
76	3,376	3,196	3,862	909	3,112	2,274
77	3,494	3,308	3,998	941	3,221	2,350
78	3,612	3,424	4,134	973	3,334	2,429
79	3,726	3,527	4,261	1,004	3,434	2,509
80	3,842	3,641	4,397	1,036	3,548	2,593
81	3,965	3,756	4,536	1,069	3,655	2,674
82	4,079	3,864	4,673	1,100	3,763	2,754
83	4,210	3,986	4,814	1,134	3,880	2,838
84	4,330	4,099	4,957	1,167	3,994	2,921
85	4,486	4,249	5,136	1,210	4,138	3,028
86	4,615	4,373	5,284	1,244	4,258	3,113
87	4,747	4,495	5,431	1,279	4,379	3,202
88	4,879	4,624	5,584	1,315	4,500	3,289
89	5,014	4,751	5,740	1,353	4,627	3,384
90	5,153	4,882	5,897	1,389	4,751	3,476
91	5,292	5,014	6,056	1,426	4,879	3,571
92	5,435	5,152	6,221	1,465	5,014	3,665
93	5,581	5,287	6,386	1,506	5,146	3,764
94	5,729	5,426	6,556	1,544	5,282	3,863
95	5,878	5,568	6,726	1,584	5,422	3,965
96	6,031	5,712	6,900	1,625	5,560	4,066
97	6,182	5,857	7,076	1,667	5,701	4,171
98	6,338	6,005	7,256	1,709	5,848	4,277
99+	6,497	6,155	7,436	1,750	5,993	4,382

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 $1,676	$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