Aetna Health and Life Insurance Company

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Outline of Coverage

Medicare Supplement Insurance

BENEFIT PLANS A, B, F, High Deductible F, G, N

Underwritten by

Aetna Health and Life Insurance Company

Illinois

AETNA HEALTH AND LIFE INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 2
BENEFIT PLANS AVAILABLE: A, B, F, HIGH DEDUCTIBLE F, G, N

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A" Some plans may not be available in your state.

Basic Benefits:
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-Approved expenses) or, co-payments for hospital outpatient services.
Plans K, L, and N require insureds to pay a portion of coinsurance or copayments
Blood: First three pints of blood each year.
Hospice-Part A coinsurance

A	B	C	D	F/F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $4,960; paid at 100% after limit reached	Out-of-pocket limit $2,480; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2,180. 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.

Aetna Health and Life Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: 600-608

Female Rates

Attained Age	Preferred					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	2,695	3,956	4,648	1,860	3,690	3,076
65	1,477	1,525	1,793	716	1,422	1,186
66	1,507	1,564	1,837	736	1,459	1,216
67	1,538	1,604	1,884	754	1,496	1,247
68	1,570	1,645	1,932	772	1,534	1,278
69	1,602	1,686	1,980	792	1,572	1,312
70	1,634	1,729	2,032	812	1,613	1,344
71	1,668	1,789	2,102	841	1,670	1,392
72	1,700	1,853	2,178	871	1,729	1,441
73	1,736	1,920	2,255	902	1,789	1,492
74	1,772	1,988	2,335	934	1,854	1,546
75	1,808	2,059	2,419	968	1,921	1,600
76	1,846	2,132	2,504	1,002	1,988	1,657
77	1,884	2,208	2,594	1,038	2,059	1,717
78	1,924	2,288	2,688	1,075	2,135	1,778
79	1,964	2,370	2,784	1,115	2,210	1,843
80	2,006	2,456	2,885	1,153	2,291	1,909
81	2,047	2,542	2,987	1,194	2,370	1,976
82	2,087	2,628	3,088	1,235	2,452	2,042
83	2,134	2,720	3,197	1,278	2,538	2,116
84	2,179	2,815	3,307	1,322	2,626	2,189
85	2,219	2,900	3,407	1,362	2,705	2,255
86	2,256	2,986	3,506	1,403	2,784	2,322
87	2,294	3,070	3,606	1,442	2,862	2,387
88	2,333	3,152	3,704	1,482	2,940	2,452
89	2,370	3,235	3,800	1,520	3,017	2,515
90	2,405	3,316	3,896	1,559	3,092	2,579
91	2,442	3,396	3,989	1,596	3,167	2,641
92	2,477	3,474	4,080	1,632	3,240	2,700
93	2,510	3,550	4,171	1,668	3,311	2,760
94	2,544	3,624	4,258	1,703	3,379	2,818
95	2,576	3,695	4,342	1,736	3,448	2,874
96	2,608	3,766	4,423	1,769	3,512	2,927
97	2,638	3,832	4,501	1,801	3,574	2,980
98	2,668	3,895	4,577	1,830	3,632	3,029
99+	2,695	3,956	4,648	1,860	3,690	3,076

Attained Age	Standard					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	2,994	4,396	5,165	2,065	4,099	3,418
65	1,640	1,694	1,992	797	1,580	1,318
66	1,675	1,738	2,040	817	1,620	1,351
67	1,709	1,782	2,094	836	1,662	1,385
68	1,744	1,828	2,147	857	1,704	1,421
69	1,780	1,872	2,201	881	1,746	1,458
70	1,817	1,921	2,256	904	1,793	1,493
71	1,853	1,988	2,336	934	1,856	1,547
72	1,890	2,059	2,419	968	1,921	1,602
73	1,930	2,134	2,506	1,002	1,988	1,657
74	1,969	2,209	2,594	1,038	2,060	1,717
75	2,010	2,288	2,688	1,076	2,135	1,778
76	2,051	2,369	2,783	1,115	2,209	1,842
77	2,094	2,454	2,884	1,153	2,288	1,908
78	2,137	2,543	2,987	1,194	2,371	1,975
79	2,183	2,633	3,094	1,237	2,456	2,048
80	2,228	2,730	3,205	1,282	2,545	2,122
81	2,274	2,824	3,319	1,327	2,633	2,197
82	2,318	2,921	3,431	1,373	2,723	2,269
83	2,370	3,024	3,552	1,421	2,820	2,351
84	2,420	3,128	3,674	1,470	2,917	2,432
85	2,465	3,222	3,786	1,513	3,005	2,506
86	2,507	3,317	3,896	1,560	3,094	2,580
87	2,549	3,410	4,007	1,603	3,180	2,651
88	2,592	3,502	4,116	1,646	3,266	2,723
89	2,633	3,595	4,223	1,690	3,353	2,795
90	2,672	3,685	4,328	1,732	3,436	2,864
91	2,713	3,774	4,432	1,774	3,520	2,934
92	2,752	3,859	4,534	1,814	3,600	3,001
93	2,790	3,944	4,634	1,853	3,679	3,067
94	2,826	4,027	4,730	1,892	3,755	3,131
95	2,862	4,106	4,824	1,930	3,830	3,193
96	2,898	4,183	4,914	1,967	3,902	3,252
97	2,930	4,258	5,002	2,000	3,970	3,310
98	2,964	4,327	5,086	2,034	4,036	3,366
99+	2,994	4,396	5,165	2,065	4,099	3,418

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

The above rates do not include the $20 application fee.

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

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

Aetna Health and Life Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: 600-608

Male Rates

Attained Age	Preferred					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	3,100	4,550	5,345	2,138	4,243	3,538
65	1,698	1,754	2,060	823	1,636	1,363
66	1,734	1,798	2,113	846	1,678	1,398
67	1,768	1,844	2,166	866	1,720	1,434
68	1,805	1,891	2,222	888	1,764	1,470
69	1,842	1,938	2,278	911	1,807	1,508
70	1,880	1,988	2,336	935	1,854	1,547
71	1,918	2,058	2,418	967	1,921	1,600
72	1,956	2,132	2,504	1,002	1,988	1,657
73	1,997	2,207	2,593	1,037	2,058	1,716
74	2,038	2,286	2,686	1,074	2,134	1,777
75	2,080	2,369	2,782	1,114	2,209	1,841
76	2,123	2,452	2,880	1,152	2,286	1,906
77	2,166	2,539	2,984	1,193	2,369	1,975
78	2,212	2,632	3,091	1,236	2,455	2,045
79	2,260	2,725	3,202	1,280	2,543	2,119
80	2,308	2,825	3,317	1,327	2,634	2,196
81	2,353	2,923	3,434	1,374	2,725	2,273
82	2,400	3,023	3,550	1,421	2,819	2,350
83	2,454	3,130	3,676	1,470	2,918	2,432
84	2,506	3,238	3,803	1,522	3,019	2,518
85	2,551	3,335	3,918	1,567	3,110	2,593
86	2,594	3,433	4,033	1,613	3,202	2,670
87	2,640	3,530	4,147	1,658	3,292	2,743
88	2,683	3,625	4,260	1,704	3,380	2,819
89	2,725	3,719	4,370	1,747	3,470	2,892
90	2,767	3,814	4,480	1,793	3,557	2,965
91	2,808	3,906	4,586	1,836	3,643	3,036
92	2,848	3,995	4,692	1,877	3,726	3,104
93	2,887	4,084	4,796	1,918	3,808	3,175
94	2,926	4,168	4,896	1,958	3,887	3,240
95	2,963	4,249	4,993	1,997	3,965	3,305
96	2,999	4,330	5,087	2,035	4,039	3,366
97	3,034	4,406	5,177	2,071	4,109	3,426
98	3,068	4,478	5,263	2,105	4,177	3,482
99+	3,100	4,550	5,345	2,138	4,243	3,538

Attained Age	Standard					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	3,443	5,054	5,939	2,376	4,714	3,930
65	1,888	1,949	2,291	916	1,817	1,514
66	1,927	1,998	2,347	938	1,864	1,553
67	1,964	2,050	2,408	962	1,912	1,592
68	2,006	2,102	2,468	986	1,960	1,634
69	2,047	2,154	2,531	1,013	2,009	1,676
70	2,089	2,209	2,594	1,039	2,060	1,717
71	2,132	2,286	2,688	1,074	2,135	1,778
72	2,174	2,369	2,782	1,114	2,209	1,842
73	2,220	2,454	2,882	1,152	2,286	1,906
74	2,264	2,542	2,984	1,193	2,370	1,975
75	2,311	2,632	3,091	1,237	2,455	2,045
76	2,358	2,723	3,200	1,280	2,542	2,118
77	2,408	2,821	3,316	1,327	2,632	2,195
78	2,458	2,924	3,434	1,374	2,728	2,272
79	2,509	3,029	3,558	1,423	2,825	2,356
80	2,563	3,139	3,686	1,475	2,927	2,440
81	2,615	3,247	3,816	1,525	3,029	2,526
82	2,666	3,358	3,946	1,578	3,132	2,610
83	2,725	3,478	4,085	1,634	3,244	2,704
84	2,783	3,598	4,225	1,691	3,354	2,797
85	2,836	3,706	4,352	1,741	3,455	2,882
86	2,884	3,815	4,480	1,794	3,558	2,966
87	2,932	3,922	4,608	1,843	3,658	3,049
88	2,982	4,027	4,733	1,892	3,756	3,132
89	3,029	4,134	4,856	1,943	3,856	3,215
90	3,073	4,238	4,978	1,991	3,950	3,294
91	3,120	4,340	5,096	2,039	4,048	3,374
92	3,163	4,438	5,214	2,086	4,140	3,451
93	3,208	4,536	5,328	2,132	4,231	3,527
94	3,250	4,631	5,441	2,177	4,319	3,600
95	3,292	4,722	5,548	2,220	4,405	3,672
96	3,332	4,811	5,651	2,262	4,488	3,740
97	3,371	4,896	5,752	2,302	4,565	3,806
98	3,409	4,976	5,849	2,339	4,642	3,871
99+	3,443	5,054	5,939	2,376	4,714	3,930

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

The above rates do not include the $20 application fee.

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

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

Aetna Health and Life Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of State

Female Rates

Attained Age	Preferred					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	2,246	3,297	3,873	1,550	3,075	2,563
65	1,231	1,271	1,494	597	1,185	988
66	1,256	1,303	1,531	613	1,216	1,013
67	1,282	1,337	1,570	628	1,247	1,039
68	1,308	1,371	1,610	643	1,278	1,065
69	1,335	1,405	1,650	660	1,310	1,093
70	1,362	1,441	1,693	677	1,344	1,120
71	1,390	1,491	1,752	701	1,392	1,160
72	1,417	1,544	1,815	726	1,441	1,201
73	1,447	1,600	1,879	752	1,491	1,243
74	1,477	1,657	1,946	778	1,545	1,288
75	1,507	1,716	2,016	807	1,601	1,333
76	1,538	1,777	2,087	835	1,657	1,381
77	1,570	1,840	2,162	865	1,716	1,431
78	1,603	1,907	2,240	896	1,779	1,482
79	1,637	1,975	2,320	929	1,842	1,536
80	1,672	2,047	2,404	961	1,909	1,591
81	1,706	2,118	2,489	995	1,975	1,647
82	1,739	2,190	2,573	1,029	2,043	1,702
83	1,778	2,267	2,664	1,065	2,115	1,763
84	1,816	2,346	2,756	1,102	2,188	1,824
85	1,849	2,417	2,839	1,135	2,254	1,879
86	1,880	2,488	2,922	1,169	2,320	1,935
87	1,912	2,558	3,005	1,202	2,385	1,989
88	1,944	2,627	3,087	1,235	2,450	2,043
89	1,975	2,696	3,167	1,267	2,514	2,096
90	2,004	2,763	3,247	1,299	2,577	2,149
91	2,035	2,830	3,324	1,330	2,639	2,201
92	2,064	2,895	3,400	1,360	2,700	2,250
93	2,092	2,958	3,476	1,390	2,759	2,300
94	2,120	3,020	3,548	1,419	2,816	2,348
95	2,147	3,079	3,618	1,447	2,873	2,395
96	2,173	3,138	3,686	1,474	2,927	2,439
97	2,198	3,193	3,751	1,501	2,978	2,483
98	2,223	3,246	3,814	1,525	3,027	2,524
99+	2,246	3,297	3,873	1,550	3,075	2,563

Attained Age	Standard					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	2,495	3,663	4,304	1,721	3,416	2,848
65	1,367	1,412	1,660	664	1,317	1,098
66	1,396	1,448	1,700	681	1,350	1,126
67	1,424	1,485	1,745	697	1,385	1,154
68	1,453	1,523	1,789	714	1,420	1,184
69	1,483	1,560	1,834	734	1,455	1,215
70	1,514	1,601	1,880	753	1,494	1,244
71	1,544	1,657	1,947	778	1,547	1,289
72	1,575	1,716	2,016	807	1,601	1,335
73	1,608	1,778	2,088	835	1,657	1,381
74	1,641	1,841	2,162	865	1,717	1,431
75	1,675	1,907	2,240	897	1,779	1,482
76	1,709	1,974	2,319	929	1,841	1,535
77	1,745	2,045	2,403	961	1,907	1,590
78	1,781	2,119	2,489	995	1,976	1,646
79	1,819	2,194	2,578	1,031	2,047	1,707
80	1,857	2,275	2,671	1,068	2,121	1,768
81	1,895	2,353	2,766	1,106	2,194	1,831
82	1,932	2,434	2,859	1,144	2,269	1,891
83	1,975	2,520	2,960	1,184	2,350	1,959
84	2,017	2,607	3,062	1,225	2,431	2,027
85	2,054	2,685	3,155	1,261	2,504	2,088
86	2,089	2,764	3,247	1,300	2,578	2,150
87	2,124	2,842	3,339	1,336	2,650	2,209
88	2,160	2,918	3,430	1,372	2,722	2,269
89	2,194	2,996	3,519	1,408	2,794	2,329
90	2,227	3,071	3,607	1,443	2,863	2,387
91	2,261	3,145	3,693	1,478	2,933	2,445
92	2,293	3,216	3,778	1,512	3,000	2,501
93	2,325	3,287	3,862	1,544	3,066	2,556
94	2,355	3,356	3,942	1,577	3,129	2,609
95	2,385	3,422	4,020	1,608	3,192	2,661
96	2,415	3,486	4,095	1,639	3,252	2,710
97	2,442	3,548	4,168	1,667	3,308	2,758
98	2,470	3,606	4,238	1,695	3,363	2,805
99+	2,495	3,663	4,304	1,721	3,416	2,848

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

The above rates do not include the $20 application fee.

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

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

Aetna Health and Life Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of State

Male Rates

Attained Age	Preferred					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	2,583	3,792	4,454	1,782	3,536	2,948
65	1,415	1,462	1,717	686	1,363	1,136
66	1,445	1,498	1,761	705	1,398	1,165
67	1,473	1,537	1,805	722	1,433	1,195
68	1,504	1,576	1,852	740	1,470	1,225
69	1,535	1,615	1,898	759	1,506	1,257
70	1,567	1,657	1,947	779	1,545	1,289
71	1,598	1,715	2,015	806	1,601	1,333
72	1,630	1,777	2,087	835	1,657	1,381
73	1,664	1,839	2,161	864	1,715	1,430
74	1,698	1,905	2,238	895	1,778	1,481
75	1,733	1,974	2,318	928	1,841	1,534
76	1,769	2,043	2,400	960	1,905	1,588
77	1,805	2,116	2,487	994	1,974	1,646
78	1,843	2,193	2,576	1,030	2,046	1,704
79	1,883	2,271	2,668	1,067	2,119	1,766
80	1,923	2,354	2,764	1,106	2,195	1,830
81	1,961	2,436	2,862	1,145	2,271	1,894
82	2,000	2,519	2,958	1,184	2,349	1,958
83	2,045	2,608	3,063	1,225	2,432	2,027
84	2,088	2,698	3,169	1,268	2,516	2,098
85	2,126	2,779	3,265	1,306	2,592	2,161
86	2,162	2,861	3,361	1,344	2,668	2,225
87	2,200	2,942	3,456	1,382	2,743	2,286
88	2,236	3,021	3,550	1,420	2,817	2,349
89	2,271	3,099	3,642	1,456	2,892	2,410
90	2,306	3,178	3,733	1,494	2,964	2,471
91	2,340	3,255	3,822	1,530	3,036	2,530
92	2,373	3,329	3,910	1,564	3,105	2,587
93	2,406	3,403	3,997	1,598	3,173	2,646
94	2,438	3,473	4,080	1,632	3,239	2,700
95	2,469	3,541	4,161	1,664	3,304	2,754
96	2,499	3,608	4,239	1,696	3,366	2,805
97	2,528	3,672	4,314	1,726	3,424	2,855
98	2,557	3,732	4,386	1,754	3,481	2,902
99+	2,583	3,792	4,454	1,782	3,536	2,948

Attained Age	Standard					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	2,869	4,212	4,949	1,980	3,928	3,275
65	1,573	1,624	1,909	763	1,514	1,262
66	1,606	1,665	1,956	782	1,553	1,294
67	1,637	1,708	2,007	802	1,593	1,327
68	1,672	1,752	2,057	822	1,633	1,362
69	1,706	1,795	2,109	844	1,674	1,397
70	1,741	1,841	2,162	866	1,717	1,431
71	1,777	1,905	2,240	895	1,779	1,482
72	1,812	1,974	2,318	928	1,841	1,535
73	1,850	2,045	2,402	960	1,905	1,588
74	1,887	2,118	2,487	994	1,975	1,646
75	1,926	2,193	2,576	1,031	2,046	1,704
76	1,965	2,269	2,667	1,067	2,118	1,765
77	2,007	2,351	2,763	1,106	2,193	1,829
78	2,048	2,437	2,862	1,145	2,273	1,893
79	2,091	2,524	2,965	1,186	2,354	1,963
80	2,136	2,616	3,072	1,229	2,439	2,033
81	2,179	2,706	3,180	1,271	2,524	2,105
82	2,222	2,798	3,288	1,315	2,610	2,175
83	2,271	2,898	3,404	1,362	2,703	2,253
84	2,319	2,998	3,521	1,409	2,795	2,331
85	2,363	3,088	3,627	1,451	2,879	2,402
86	2,403	3,179	3,733	1,495	2,965	2,472
87	2,443	3,268	3,840	1,536	3,048	2,541
88	2,485	3,356	3,944	1,577	3,130	2,610
89	2,524	3,445	4,047	1,619	3,213	2,679
90	2,561	3,532	4,148	1,659	3,292	2,745
91	2,600	3,617	4,247	1,699	3,373	2,812
92	2,636	3,698	4,345	1,738	3,450	2,876
93	2,673	3,780	4,440	1,777	3,526	2,939
94	2,708	3,859	4,534	1,814	3,599	3,000
95	2,743	3,935	4,623	1,850	3,671	3,060
96	2,777	4,009	4,709	1,885	3,740	3,117
97	2,809	4,080	4,793	1,918	3,804	3,172
98	2,841	4,147	4,874	1,949	3,868	3,226
99+	2,869	4,212	4,949	1,980	3,928	3,275

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

The above rates do not include the $20 application fee.

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

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

PREMIUM INFORMATION

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

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

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

HOUSEHOLD DISCOUNT

In order to be eligible for the Household discount under an Aetna Health and Life Insurance Company Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently be covered by an Aetna Health and Life Insurance Company Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (b) be someone with whom you are in a civil union partnership; or (c) be a permanent resident in your home. 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 1188, Brentwood, Tennessee 37024. 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 $1,288	$0	$1,288 (Part A Deductible)
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	$0	Up to $161 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.

PLAN A

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

*Once you have been billed $166 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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

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 $1,288	$1,288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	$0	Up to $161 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN B

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

* Once you have been billed $166 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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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 $1,288	$1,288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	Up to $161 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN F

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

*Once you have been billed $166 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 $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$166 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

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

High Deductible 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 $2,180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,180. 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 $2,180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,180 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,288	$1,288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	Up to $161 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

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

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

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $166 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 $2,180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,180. 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 $2,180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,180 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 $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$166 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,180 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $166 of Medicare Approved amounts*	$0	$166 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,180 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

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 $1,288	$1,288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	Up to $161 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN G

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

*Once you have been billed $166 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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

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

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 $1,288	$1,288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	Up to $161 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

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

PLAN N

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

*Once you have been billed $166 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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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 $166 of Medicare Approved amounts*	$0	$0	$166 (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