aetna®

Aetna Health and Life Insurance Company

Administrative Office
800 Crescent Centre Dr.
Suite 200
Franklin, TN 37067
800 264.4000
aetnaseniorproducts.com

Outline of Coverage

Medicare Supplement Insurance

BENEFIT PLANS A, B, F, HIGH DEDUCTIBLE F, G, N

Underwritten by

Aetna Health and Life Insurance Company

Kentucky

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" and either Plan "C" or Plan "F". 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, copayments 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 $4960; paid at 100% after limit reached	Out-of-pocket limit $2480; paid at 100% after limit reached		

*Plans 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 $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2180. 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: 402, 410, 416-418

Female Rates

Attained	Preferred					
Age	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	3,602	---	5,640	---	---	---
65	1,065	1,206	1,627	651	1,289	1,179
66	1,095	1,245	1,684	673	1,333	1,220
67	1,125	1,283	1,737	695	1,377	1,260
68	1,155	1,321	1,791	716	1,420	1,302
69	1,183	1,360	1,843	738	1,464	1,342
70	1,211	1,397	1,896	758	1,507	1,381
71	1,240	1,434	1,948	779	1,548	1,421
72	1,268	1,471	2,000	799	1,589	1,459
73	1,291	1,507	2,053	821	1,634	1,502
74	1,316	1,543	2,106	843	1,679	1,544
75	1,339	1,579	2,159	864	1,723	1,587
76	1,362	1,616	2,211	886	1,765	1,627
77	1,385	1,651	2,263	906	1,808	1,669
78	1,400	1,684	2,315	926	1,852	1,712
79	1,415	1,717	2,367	946	1,896	1,755
80	1,429	1,749	2,417	967	1,940	1,797
81	1,444	1,783	2,468	987	1,983	1,840
82	1,458	1,815	2,517	1,007	2,025	1,883
83	1,477	1,843	2,568	1,028	2,070	1,927
84	1,496	1,872	2,617	1,047	2,114	1,972
85	1,510	1,895	2,660	1,064	2,153	2,011
86	1,525	1,919	2,704	1,082	2,192	2,053
87	1,539	1,944	2,747	1,099	2,232	2,095
88	1,554	1,969	2,793	1,117	2,274	2,138
89	1,569	1,993	2,836	1,135	2,314	2,179
90	1,584	2,016	2,881	1,152	2,354	2,221
91	1,600	2,040	2,923	1,170	2,394	2,262
92	1,615	2,063	2,967	1,187	2,433	2,302
93	1,631	2,086	3,010	1,204	2,471	2,343
94	1,646	2,107	3,050	1,220	2,510	2,383
95	1,662	2,129	3,091	1,236	2,547	2,421
96	1,678	2,151	3,131	1,252	2,584	2,460
97	1,694	2,172	3,171	1,270	2,621	2,498
98	1,711	2,193	3,211	1,283	2,657	2,536
99+	1,726	2,214	3,250	1,300	2,692	2,573

Attained	Standard					
Age	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	4,002	---	6,265	---	---	---
65	1,183	1,341	1,809	723	1,432	1,309
66	1,217	1,383	1,870	748	1,481	1,355
67	1,250	1,426	1,930	772	1,530	1,401
68	1,282	1,469	1,990	796	1,578	1,447
69	1,314	1,511	2,049	820	1,626	1,490
70	1,346	1,553	2,106	843	1,673	1,535
71	1,378	1,593	2,164	866	1,720	1,579
72	1,409	1,634	2,222	889	1,766	1,622
73	1,435	1,674	2,280	913	1,816	1,669
74	1,462	1,715	2,340	937	1,865	1,716
75	1,487	1,755	2,399	959	1,914	1,763
76	1,513	1,795	2,456	983	1,961	1,809
77	1,539	1,834	2,514	1,006	2,009	1,855
78	1,555	1,871	2,573	1,029	2,057	1,903
79	1,572	1,908	2,630	1,052	2,107	1,949
80	1,588	1,944	2,685	1,075	2,155	1,998
81	1,604	1,980	2,743	1,096	2,203	2,045
82	1,620	2,016	2,798	1,119	2,251	2,092
83	1,641	2,048	2,853	1,142	2,300	2,141
84	1,662	2,080	2,908	1,163	2,348	2,191
85	1,678	2,106	2,956	1,182	2,392	2,236
86	1,694	2,132	3,004	1,203	2,436	2,280
87	1,710	2,160	3,052	1,221	2,481	2,328
88	1,726	2,187	3,104	1,241	2,527	2,375
89	1,743	2,214	3,152	1,260	2,571	2,422
90	1,760	2,240	3,202	1,280	2,615	2,467
91	1,777	2,267	3,249	1,301	2,660	2,513
92	1,794	2,292	3,297	1,319	2,704	2,559
93	1,811	2,317	3,343	1,337	2,746	2,604
94	1,829	2,341	3,389	1,355	2,789	2,647
95	1,847	2,366	3,434	1,374	2,830	2,690
96	1,864	2,390	3,479	1,392	2,872	2,732
97	1,883	2,414	3,524	1,410	2,912	2,776
98	1,901	2,437	3,567	1,426	2,952	2,818
99+	1,918	2,460	3,611	1,444	2,991	2,858

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

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: 402, 410, 416-418

Male Rates

Attained	Preferred					
Age	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	4,142	---	6,486	---	---	---
65	1,225	1,388	1,872	749	1,482	1,355
66	1,259	1,432	1,935	774	1,533	1,403
67	1,294	1,475	1,998	798	1,584	1,450
68	1,327	1,520	2,059	823	1,633	1,497
69	1,360	1,564	2,121	849	1,682	1,543
70	1,393	1,608	2,180	872	1,732	1,589
71	1,426	1,649	2,240	896	1,780	1,635
72	1,458	1,692	2,299	919	1,827	1,679
73	1,486	1,733	2,361	944	1,879	1,728
74	1,513	1,776	2,422	969	1,931	1,777
75	1,539	1,817	2,483	992	1,981	1,825
76	1,566	1,858	2,543	1,018	2,030	1,872
77	1,593	1,899	2,602	1,042	2,079	1,918
78	1,610	1,937	2,662	1,065	2,129	1,970
79	1,627	1,975	2,722	1,089	2,180	2,018
80	1,643	2,013	2,780	1,112	2,231	2,068
81	1,661	2,049	2,839	1,135	2,280	2,117
82	1,677	2,086	2,896	1,158	2,330	2,165
83	1,699	2,119	2,953	1,182	2,381	2,216
84	1,720	2,153	3,011	1,204	2,430	2,268
85	1,737	2,179	3,059	1,224	2,476	2,314
86	1,754	2,207	3,110	1,244	2,521	2,361
87	1,770	2,236	3,159	1,264	2,568	2,409
88	1,786	2,263	3,212	1,285	2,615	2,459
89	1,804	2,292	3,261	1,305	2,661	2,507
90	1,822	2,318	3,313	1,325	2,707	2,554
91	1,839	2,346	3,361	1,346	2,753	2,601
92	1,857	2,372	3,412	1,365	2,799	2,648
93	1,875	2,398	3,460	1,385	2,842	2,694
94	1,893	2,423	3,508	1,403	2,887	2,739
95	1,911	2,448	3,555	1,423	2,929	2,784
96	1,930	2,474	3,601	1,441	2,973	2,829
97	1,949	2,499	3,647	1,459	3,014	2,873
98	1,968	2,522	3,693	1,475	3,056	2,916
99+	1,985	2,546	3,738	1,494	3,096	2,959

Attained	Standard					
Age	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	4,602	---	7,205	---	---	---
65	1,360	1,542	2,080	831	1,646	1,505
66	1,400	1,592	2,151	860	1,703	1,558
67	1,438	1,641	2,220	888	1,760	1,611
68	1,475	1,689	2,289	915	1,815	1,664
69	1,512	1,738	2,358	943	1,870	1,714
70	1,548	1,786	2,422	969	1,925	1,765
71	1,585	1,832	2,489	996	1,978	1,816
72	1,620	1,879	2,555	1,021	2,032	1,864
73	1,651	1,926	2,623	1,049	2,087	1,918
74	1,681	1,972	2,691	1,078	2,145	1,973
75	1,711	2,018	2,759	1,103	2,200	2,027
76	1,740	2,064	2,824	1,130	2,254	2,080
77	1,770	2,109	2,891	1,157	2,310	2,132
78	1,787	2,152	2,959	1,183	2,366	2,188
79	1,808	2,193	3,025	1,210	2,423	2,241
80	1,826	2,236	3,089	1,236	2,478	2,297
81	1,846	2,277	3,154	1,260	2,533	2,351
82	1,864	2,318	3,218	1,287	2,588	2,406
83	1,888	2,355	3,281	1,313	2,645	2,462
84	1,911	2,393	3,345	1,336	2,700	2,519
85	1,930	2,421	3,399	1,359	2,751	2,570
86	1,949	2,452	3,455	1,382	2,800	2,623
87	1,967	2,484	3,510	1,404	2,853	2,677
88	1,985	2,515	3,570	1,427	2,905	2,731
89	2,004	2,546	3,625	1,450	2,957	2,785
90	2,024	2,576	3,681	1,472	3,007	2,836
91	2,045	2,607	3,736	1,496	3,059	2,890
92	2,063	2,635	3,792	1,517	3,110	2,943
93	2,084	2,666	3,844	1,539	3,158	2,993
94	2,103	2,692	3,897	1,558	3,206	3,044
95	2,124	2,721	3,950	1,580	3,255	3,094
96	2,144	2,749	4,001	1,600	3,302	3,142
97	2,165	2,776	4,053	1,622	3,349	3,192
98	2,187	2,801	4,102	1,640	3,395	3,240
99+	2,206	2,830	4,153	1,661	3,441	3,287

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

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	3,132	---	4,904	---	---	---
65	926	1,049	1,415	566	1,121	1,025
66	952	1,083	1,464	585	1,159	1,061
67	978	1,116	1,510	604	1,197	1,096
68	1,004	1,149	1,557	623	1,235	1,132
69	1,029	1,183	1,603	642	1,273	1,167
70	1,053	1,215	1,649	659	1,310	1,201
71	1,078	1,247	1,694	677	1,346	1,236
72	1,103	1,279	1,739	695	1,382	1,269
73	1,123	1,310	1,785	714	1,421	1,306
74	1,144	1,342	1,831	733	1,460	1,343
75	1,164	1,373	1,877	751	1,498	1,380
76	1,184	1,405	1,923	770	1,535	1,415
77	1,204	1,436	1,968	788	1,572	1,451
78	1,217	1,464	2,013	805	1,610	1,489
79	1,230	1,493	2,058	823	1,649	1,526
80	1,243	1,521	2,102	841	1,687	1,563
81	1,256	1,550	2,146	858	1,724	1,600
82	1,268	1,578	2,189	876	1,761	1,637
83	1,284	1,603	2,233	894	1,800	1,676
84	1,301	1,628	2,276	910	1,838	1,715
85	1,313	1,648	2,313	925	1,872	1,749
86	1,326	1,669	2,351	941	1,906	1,785
87	1,338	1,690	2,389	956	1,941	1,822
88	1,351	1,712	2,429	971	1,977	1,859
89	1,364	1,733	2,466	987	2,012	1,895
90	1,377	1,753	2,505	1,002	2,047	1,931
91	1,391	1,774	2,542	1,017	2,082	1,967
92	1,404	1,794	2,580	1,032	2,116	2,002
93	1,418	1,814	2,617	1,047	2,149	2,037
94	1,431	1,832	2,652	1,061	2,183	2,072
95	1,445	1,851	2,688	1,075	2,215	2,105
96	1,459	1,870	2,723	1,089	2,247	2,139
97	1,473	1,889	2,757	1,104	2,279	2,172
98	1,488	1,907	2,792	1,116	2,310	2,205
99+	1,501	1,925	2,826	1,130	2,341	2,237

Attained Age	Standard					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	3,480	---	5,448	---	---	---
65	1,029	1,166	1,573	629	1,245	1,138
66	1,058	1,203	1,626	650	1,288	1,178
67	1,087	1,240	1,678	671	1,330	1,218
68	1,115	1,277	1,730	692	1,372	1,258
69	1,143	1,314	1,782	713	1,414	1,296
70	1,170	1,350	1,831	733	1,455	1,335
71	1,198	1,385	1,882	753	1,496	1,373
72	1,225	1,421	1,932	773	1,536	1,410
73	1,248	1,456	1,983	794	1,579	1,451
74	1,271	1,491	2,035	815	1,622	1,492
75	1,293	1,526	2,086	834	1,664	1,533
76	1,316	1,561	2,136	855	1,705	1,573
77	1,338	1,595	2,186	875	1,747	1,613
78	1,352	1,627	2,237	895	1,789	1,655
79	1,367	1,659	2,287	915	1,832	1,695
80	1,381	1,690	2,335	935	1,874	1,737
81	1,395	1,722	2,385	953	1,916	1,778
82	1,409	1,753	2,433	973	1,957	1,819
83	1,427	1,781	2,481	993	2,000	1,862
84	1,445	1,809	2,529	1,011	2,042	1,905
85	1,459	1,831	2,570	1,028	2,080	1,944
86	1,473	1,854	2,612	1,046	2,118	1,983
87	1,487	1,878	2,654	1,062	2,157	2,024
88	1,501	1,902	2,699	1,079	2,197	2,065
89	1,516	1,925	2,741	1,096	2,236	2,106
90	1,530	1,948	2,784	1,113	2,274	2,145
91	1,545	1,971	2,825	1,131	2,313	2,185
92	1,560	1,993	2,867	1,147	2,351	2,225
93	1,575	2,015	2,907	1,163	2,388	2,264
94	1,590	2,036	2,947	1,178	2,425	2,302
95	1,606	2,057	2,986	1,195	2,461	2,339
96	1,621	2,078	3,025	1,210	2,497	2,376
97	1,637	2,099	3,064	1,226	2,532	2,414
98	1,653	2,119	3,102	1,240	2,567	2,450
99+	1,668	2,139	3,140	1,256	2,601	2,485

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

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

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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	3,602	---	5,640	---	---	---
65	1,065	1,207	1,628	651	1,289	1,178
66	1,095	1,245	1,683	673	1,333	1,220
67	1,125	1,283	1,737	694	1,377	1,261
68	1,154	1,322	1,790	716	1,420	1,302
69	1,183	1,360	1,844	738	1,463	1,342
70	1,211	1,398	1,896	758	1,506	1,382
71	1,240	1,434	1,948	779	1,548	1,422
72	1,268	1,471	1,999	799	1,589	1,460
73	1,292	1,507	2,053	821	1,634	1,503
74	1,316	1,544	2,106	843	1,679	1,545
75	1,338	1,580	2,159	863	1,723	1,587
76	1,362	1,616	2,211	885	1,765	1,628
77	1,385	1,651	2,263	906	1,808	1,668
78	1,400	1,684	2,315	926	1,851	1,713
79	1,415	1,717	2,367	947	1,896	1,755
80	1,429	1,750	2,417	967	1,940	1,798
81	1,444	1,782	2,469	987	1,983	1,841
82	1,458	1,814	2,518	1,007	2,026	1,883
83	1,477	1,843	2,568	1,028	2,070	1,927
84	1,496	1,872	2,618	1,047	2,113	1,972
85	1,510	1,895	2,660	1,064	2,153	2,012
86	1,525	1,919	2,704	1,082	2,192	2,053
87	1,539	1,944	2,747	1,099	2,233	2,095
88	1,553	1,968	2,793	1,117	2,274	2,138
89	1,569	1,993	2,836	1,135	2,314	2,180
90	1,584	2,016	2,881	1,152	2,354	2,221
91	1,599	2,040	2,923	1,170	2,394	2,262
92	1,615	2,063	2,967	1,187	2,434	2,303
93	1,630	2,085	3,009	1,204	2,471	2,343
94	1,646	2,107	3,050	1,220	2,510	2,382
95	1,662	2,129	3,091	1,237	2,547	2,421
96	1,678	2,151	3,131	1,253	2,585	2,460
97	1,695	2,173	3,171	1,269	2,621	2,498
98	1,711	2,193	3,211	1,283	2,657	2,536
99+	1,726	2,214	3,250	1,299	2,692	2,573

Attained Age	Standard					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	4,002	---	6,265	---	---	---
65	1,183	1,341	1,809	723	1,431	1,309
66	1,217	1,384	1,870	748	1,481	1,355
67	1,250	1,427	1,930	772	1,530	1,401
68	1,283	1,469	1,990	796	1,578	1,447
69	1,315	1,511	2,050	820	1,626	1,490
70	1,346	1,553	2,106	843	1,674	1,535
71	1,378	1,593	2,164	866	1,720	1,579
72	1,409	1,634	2,222	888	1,767	1,621
73	1,436	1,675	2,281	912	1,815	1,668
74	1,462	1,715	2,340	937	1,865	1,716
75	1,488	1,755	2,399	959	1,913	1,763
76	1,513	1,795	2,456	983	1,960	1,809
77	1,539	1,834	2,514	1,006	2,009	1,854
78	1,554	1,871	2,573	1,029	2,057	1,903
79	1,572	1,907	2,630	1,052	2,107	1,949
80	1,588	1,944	2,686	1,075	2,155	1,997
81	1,605	1,980	2,743	1,096	2,203	2,044
82	1,621	2,016	2,798	1,119	2,250	2,092
83	1,642	2,048	2,853	1,142	2,300	2,141
84	1,662	2,081	2,909	1,162	2,348	2,190
85	1,678	2,105	2,956	1,182	2,392	2,235
86	1,695	2,132	3,004	1,202	2,435	2,281
87	1,710	2,160	3,052	1,221	2,481	2,328
88	1,726	2,187	3,104	1,241	2,526	2,375
89	1,743	2,214	3,152	1,261	2,571	2,422
90	1,760	2,240	3,201	1,280	2,615	2,466
91	1,778	2,267	3,249	1,301	2,660	2,513
92	1,794	2,291	3,297	1,319	2,704	2,559
93	1,812	2,318	3,343	1,338	2,746	2,603
94	1,829	2,341	3,389	1,355	2,788	2,647
95	1,847	2,366	3,435	1,374	2,830	2,690
96	1,864	2,390	3,479	1,391	2,871	2,732
97	1,883	2,414	3,524	1,410	2,912	2,776
98	1,902	2,436	3,567	1,426	2,952	2,817
99+	1,918	2,461	3,611	1,444	2,992	2,858

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

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 $1288	$0	$1288 (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 test, 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 $1288	$1288 (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 test, 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 $1288	$1288 (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 test, 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 $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2180. 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 $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (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 $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2180. 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 $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 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 test, 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 $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 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 $2180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2180 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 $1288	$1288 (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 test, 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 $1288	$1288 (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 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 test, 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 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.	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