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

OKLAHOMA

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.

See Outlines of Coverage sections for details about ALL Plans

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		

*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 $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 certificate. 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: 730, 731, 740, 741

Female Rates

Attained Age	Preferred					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	4,345	---	---	---	---	---
65	1,179	1,309	1,505	603	1,074	1,003
66	1,227	1,369	1,577	631	1,127	1,055
67	1,273	1,428	1,649	660	1,179	1,104
68	1,320	1,489	1,720	689	1,231	1,155
69	1,366	1,548	1,793	718	1,285	1,205
70	1,413	1,610	1,865	746	1,336	1,256
71	1,459	1,669	1,937	775	1,390	1,305
72	1,507	1,728	2,008	804	1,442	1,356
73	1,548	1,792	2,087	835	1,500	1,415
74	1,590	1,855	2,167	866	1,558	1,472
75	1,633	1,919	2,245	898	1,617	1,530
76	1,674	1,983	2,323	929	1,676	1,587
77	1,717	2,045	2,402	960	1,734	1,646
78	1,735	2,094	2,468	987	1,786	1,697
79	1,755	2,142	2,535	1,013	1,835	1,749
80	1,773	2,191	2,599	1,040	1,887	1,803
81	1,792	2,240	2,666	1,067	1,939	1,855
82	1,810	2,289	2,731	1,093	1,988	1,908
83	1,833	2,333	2,798	1,119	2,044	1,965
84	1,856	2,377	2,864	1,145	2,096	2,023
85	1,876	2,414	2,923	1,170	2,145	2,077
86	1,894	2,453	2,983	1,193	2,194	2,132
87	1,912	2,492	3,045	1,218	2,246	2,187
88	1,932	2,531	3,108	1,243	2,298	2,246
89	1,950	2,570	3,171	1,268	2,349	2,303
90	1,969	2,609	3,233	1,293	2,402	2,361
91	1,988	2,647	3,294	1,318	2,453	2,417
92	2,009	2,686	3,356	1,342	2,504	2,475
93	2,029	2,724	3,417	1,366	2,555	2,531
94	2,049	2,760	3,476	1,390	2,605	2,588
95	2,069	2,796	3,536	1,415	2,654	2,643
96	2,088	2,832	3,595	1,438	2,704	2,697
97	2,110	2,868	3,654	1,462	2,752	2,752
98	2,131	2,904	3,711	1,485	2,800	2,806
99+	2,152	2,937	3,769	1,508	2,847	2,859

Attained Age	Standard					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	4,828	---	---	---	---	---
65	1,310	1,455	1,672	670	1,194	1,114
66	1,363	1,521	1,751	702	1,252	1,172
67	1,413	1,587	1,833	734	1,310	1,227
68	1,467	1,656	1,911	765	1,367	1,282
69	1,518	1,720	1,993	797	1,426	1,339
70	1,571	1,788	2,072	828	1,485	1,395
71	1,623	1,854	2,152	861	1,543	1,450
72	1,673	1,921	2,231	894	1,601	1,507
73	1,720	1,992	2,320	927	1,666	1,572
74	1,768	2,061	2,407	963	1,733	1,635
75	1,815	2,132	2,494	998	1,796	1,699
76	1,861	2,203	2,582	1,033	1,862	1,764
77	1,908	2,272	2,669	1,068	1,926	1,827
78	1,929	2,325	2,743	1,097	1,984	1,886
79	1,949	2,381	2,816	1,126	2,040	1,944
80	1,970	2,435	2,888	1,156	2,096	2,003
81	1,992	2,487	2,961	1,186	2,154	2,061
82	2,011	2,543	3,035	1,214	2,209	2,121
83	2,037	2,593	3,108	1,244	2,270	2,183
84	2,063	2,642	3,182	1,273	2,329	2,248
85	2,084	2,683	3,248	1,298	2,384	2,307
86	2,105	2,726	3,315	1,325	2,439	2,369
87	2,125	2,769	3,384	1,352	2,496	2,431
88	2,146	2,813	3,453	1,381	2,553	2,496
89	2,168	2,857	3,522	1,410	2,612	2,560
90	2,187	2,898	3,593	1,436	2,668	2,622
91	2,210	2,942	3,659	1,464	2,726	2,686
92	2,232	2,984	3,728	1,493	2,782	2,750
93	2,255	3,027	3,796	1,518	2,838	2,812
94	2,276	3,067	3,863	1,544	2,895	2,875
95	2,299	3,107	3,930	1,572	2,949	2,936
96	2,321	3,146	3,994	1,597	3,005	2,997
97	2,345	3,187	4,060	1,624	3,058	3,057
98	2,368	3,227	4,123	1,649	3,111	3,118
99+	2,391	3,264	4,187	1,674	3,165	3,176

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: 730, 731, 740, 741

Male Rates

Attained Age	Preferred					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	4,996	---	---	---	---	---
65	1,356	1,505	1,731	692	1,236	1,153
66	1,410	1,574	1,815	726	1,295	1,213
67	1,464	1,643	1,896	759	1,356	1,270
68	1,518	1,714	1,979	792	1,416	1,328
69	1,571	1,780	2,063	825	1,477	1,386
70	1,626	1,852	2,145	858	1,536	1,444
71	1,679	1,919	2,228	891	1,597	1,501
72	1,732	1,987	2,308	925	1,658	1,561
73	1,780	2,060	2,401	959	1,724	1,626
74	1,830	2,133	2,491	996	1,792	1,693
75	1,878	2,207	2,582	1,033	1,860	1,760
76	1,925	2,279	2,671	1,070	1,927	1,825
77	1,973	2,352	2,762	1,105	1,994	1,892
78	1,996	2,408	2,838	1,135	2,053	1,952
79	2,017	2,464	2,915	1,165	2,111	2,013
80	2,039	2,520	2,989	1,195	2,170	2,073
81	2,060	2,575	3,065	1,227	2,230	2,133
82	2,083	2,631	3,141	1,257	2,287	2,195
83	2,108	2,684	3,217	1,288	2,349	2,260
84	2,134	2,734	3,292	1,318	2,410	2,326
85	2,156	2,776	3,361	1,346	2,467	2,387
86	2,178	2,821	3,432	1,371	2,525	2,452
87	2,200	2,866	3,503	1,400	2,582	2,516
88	2,221	2,911	3,575	1,428	2,643	2,582
89	2,243	2,956	3,646	1,459	2,703	2,650
90	2,264	3,000	3,718	1,486	2,762	2,715
91	2,287	3,044	3,788	1,515	2,821	2,780
92	2,310	3,089	3,858	1,543	2,881	2,845
93	2,333	3,131	3,930	1,571	2,938	2,912
94	2,355	3,174	3,997	1,599	2,996	2,975
95	2,379	3,215	4,066	1,627	3,053	3,039
96	2,402	3,258	4,134	1,654	3,110	3,103
97	2,427	3,299	4,201	1,680	3,165	3,164
98	2,451	3,338	4,268	1,708	3,222	3,227
99+	2,475	3,378	4,333	1,733	3,275	3,288

Attained Age	Standard					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	5,551	---	---	---	---	---
65	1,508	1,673	1,923	772	1,372	1,281
66	1,567	1,749	2,015	806	1,440	1,347
67	1,626	1,825	2,108	843	1,507	1,411
68	1,687	1,904	2,199	880	1,573	1,474
69	1,747	1,979	2,292	917	1,641	1,540
70	1,807	2,056	2,383	953	1,707	1,605
71	1,865	2,132	2,475	990	1,774	1,668
72	1,924	2,208	2,566	1,027	1,842	1,733
73	1,979	2,290	2,668	1,066	1,916	1,808
74	2,034	2,371	2,768	1,106	1,992	1,881
75	2,086	2,452	2,868	1,148	2,065	1,953
76	2,140	2,535	2,968	1,188	2,141	2,027
77	2,193	2,613	3,069	1,228	2,216	2,101
78	2,218	2,675	3,154	1,262	2,282	2,169
79	2,241	2,737	3,240	1,294	2,346	2,236
80	2,266	2,800	3,320	1,329	2,410	2,303
81	2,290	2,861	3,405	1,364	2,477	2,370
82	2,314	2,924	3,490	1,396	2,542	2,439
83	2,343	2,982	3,575	1,431	2,609	2,510
84	2,372	3,038	3,659	1,464	2,680	2,585
85	2,397	3,085	3,734	1,494	2,742	2,653
86	2,421	3,135	3,813	1,524	2,806	2,724
87	2,443	3,184	3,892	1,556	2,869	2,796
88	2,468	3,234	3,972	1,588	2,936	2,870
89	2,493	3,284	4,050	1,623	3,003	2,944
90	2,515	3,333	4,131	1,653	3,068	3,015
91	2,542	3,384	4,209	1,684	3,134	3,089
92	2,567	3,433	4,287	1,716	3,199	3,161
93	2,593	3,481	4,364	1,747	3,265	3,234
94	2,617	3,527	4,442	1,777	3,328	3,306
95	2,643	3,573	4,518	1,808	3,391	3,378
96	2,669	3,619	4,593	1,837	3,453	3,447
97	2,697	3,665	4,668	1,866	3,518	3,516
98	2,724	3,711	4,741	1,896	3,578	3,586
99+	2,749	3,754	4,815	1,925	3,639	3,654

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	3,778	---	---	---	---	---
65	1,025	1,138	1,309	524	934	872
66	1,067	1,190	1,371	549	980	917
67	1,107	1,242	1,434	574	1,025	960
68	1,148	1,295	1,496	599	1,070	1,004
69	1,188	1,346	1,559	624	1,117	1,048
70	1,229	1,400	1,622	649	1,162	1,092
71	1,269	1,451	1,684	674	1,209	1,135
72	1,310	1,503	1,746	699	1,254	1,179
73	1,346	1,558	1,815	726	1,304	1,230
74	1,383	1,613	1,884	753	1,355	1,280
75	1,420	1,669	1,952	781	1,406	1,330
76	1,456	1,724	2,020	808	1,457	1,380
77	1,493	1,778	2,089	835	1,508	1,431
78	1,509	1,821	2,146	858	1,553	1,476
79	1,526	1,863	2,204	881	1,596	1,521
80	1,542	1,905	2,260	904	1,641	1,568
81	1,558	1,948	2,318	928	1,686	1,613
82	1,574	1,990	2,375	950	1,729	1,659
83	1,594	2,029	2,433	973	1,777	1,709
84	1,614	2,067	2,490	996	1,823	1,759
85	1,631	2,099	2,542	1,017	1,865	1,806
86	1,647	2,133	2,594	1,037	1,908	1,854
87	1,663	2,167	2,648	1,059	1,953	1,902
88	1,680	2,201	2,703	1,081	1,998	1,953
89	1,696	2,235	2,757	1,103	2,043	2,003
90	1,712	2,269	2,811	1,124	2,089	2,053
91	1,729	2,302	2,864	1,146	2,133	2,102
92	1,747	2,336	2,918	1,167	2,177	2,152
93	1,764	2,369	2,971	1,188	2,222	2,201
94	1,782	2,400	3,023	1,209	2,265	2,250
95	1,799	2,431	3,075	1,230	2,308	2,298
96	1,816	2,463	3,126	1,250	2,351	2,345
97	1,835	2,494	3,177	1,271	2,393	2,393
98	1,853	2,525	3,227	1,291	2,435	2,440
99+	1,871	2,554	3,277	1,311	2,476	2,486

Attained Age	Standard					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	4,198	---	---	---	---	---
65	1,139	1,265	1,454	583	1,038	969
66	1,185	1,323	1,523	610	1,089	1,019
67	1,229	1,380	1,594	638	1,139	1,067
68	1,276	1,440	1,662	665	1,189	1,115
69	1,320	1,496	1,733	693	1,240	1,164
70	1,366	1,555	1,802	720	1,291	1,213
71	1,411	1,612	1,871	749	1,342	1,261
72	1,455	1,670	1,940	777	1,392	1,310
73	1,496	1,732	2,017	806	1,449	1,367
74	1,537	1,792	2,093	837	1,507	1,422
75	1,578	1,854	2,169	868	1,562	1,477
76	1,618	1,916	2,245	898	1,619	1,534
77	1,659	1,976	2,321	929	1,675	1,589
78	1,677	2,022	2,385	954	1,725	1,640
79	1,695	2,070	2,449	979	1,774	1,690
80	1,713	2,117	2,511	1,005	1,823	1,742
81	1,732	2,163	2,575	1,031	1,873	1,792
82	1,749	2,211	2,639	1,056	1,921	1,844
83	1,771	2,255	2,703	1,082	1,974	1,898
84	1,794	2,297	2,767	1,107	2,025	1,955
85	1,812	2,333	2,824	1,129	2,073	2,006
86	1,830	2,370	2,883	1,152	2,121	2,060
87	1,848	2,408	2,943	1,176	2,170	2,114
88	1,866	2,446	3,003	1,201	2,220	2,170
89	1,885	2,484	3,063	1,226	2,271	2,226
90	1,902	2,520	3,124	1,249	2,320	2,280
91	1,922	2,558	3,182	1,273	2,370	2,336
92	1,941	2,595	3,242	1,298	2,419	2,391
93	1,961	2,632	3,301	1,320	2,468	2,445
94	1,979	2,667	3,359	1,343	2,517	2,500
95	1,999	2,702	3,417	1,367	2,564	2,553
96	2,018	2,736	3,473	1,389	2,613	2,606
97	2,039	2,771	3,530	1,412	2,659	2,658
98	2,059	2,806	3,585	1,434	2,705	2,711
99+	2,079	2,838	3,641	1,456	2,752	2,762

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	4,344	---	---	---	---	---
65	1,179	1,309	1,505	602	1,075	1,003
66	1,226	1,369	1,578	631	1,126	1,055
67	1,273	1,429	1,649	660	1,179	1,104
68	1,320	1,490	1,721	689	1,231	1,155
69	1,366	1,548	1,794	717	1,284	1,205
70	1,414	1,610	1,865	746	1,336	1,256
71	1,460	1,669	1,937	775	1,389	1,305
72	1,506	1,728	2,007	804	1,442	1,357
73	1,548	1,791	2,088	834	1,499	1,414
74	1,591	1,855	2,166	866	1,558	1,472
75	1,633	1,919	2,245	898	1,617	1,530
76	1,674	1,982	2,323	930	1,676	1,587
77	1,716	2,045	2,402	961	1,734	1,645
78	1,736	2,094	2,468	987	1,785	1,697
79	1,754	2,143	2,535	1,013	1,836	1,750
80	1,773	2,191	2,599	1,039	1,887	1,803
81	1,791	2,239	2,665	1,067	1,939	1,855
82	1,811	2,288	2,731	1,093	1,989	1,909
83	1,833	2,334	2,797	1,120	2,043	1,965
84	1,856	2,377	2,863	1,146	2,096	2,023
85	1,875	2,414	2,923	1,170	2,145	2,076
86	1,894	2,453	2,984	1,192	2,196	2,132
87	1,913	2,492	3,046	1,217	2,245	2,188
88	1,931	2,531	3,109	1,242	2,298	2,245
89	1,950	2,570	3,170	1,269	2,350	2,304
90	1,969	2,609	3,233	1,292	2,402	2,361
91	1,989	2,647	3,294	1,317	2,453	2,417
92	2,009	2,686	3,355	1,342	2,505	2,474
93	2,029	2,723	3,417	1,366	2,555	2,532
94	2,048	2,760	3,476	1,390	2,605	2,587
95	2,069	2,796	3,536	1,415	2,655	2,643
96	2,089	2,833	3,595	1,438	2,704	2,698
97	2,110	2,869	3,653	1,461	2,752	2,751
98	2,131	2,903	3,711	1,485	2,802	2,806
99+	2,152	2,937	3,768	1,507	2,848	2,859

Attained Age	Standard					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
Under 65	4,827	---	---	---	---	---
65	1,311	1,455	1,672	671	1,193	1,114
66	1,363	1,521	1,752	701	1,252	1,171
67	1,414	1,587	1,833	733	1,310	1,227
68	1,467	1,656	1,912	765	1,368	1,282
69	1,519	1,721	1,993	797	1,427	1,339
70	1,571	1,788	2,072	829	1,484	1,396
71	1,622	1,854	2,152	861	1,543	1,450
72	1,673	1,920	2,231	893	1,602	1,507
73	1,721	1,991	2,320	927	1,666	1,572
74	1,769	2,062	2,407	962	1,732	1,636
75	1,814	2,132	2,494	998	1,796	1,698
76	1,861	2,204	2,581	1,033	1,862	1,763
77	1,907	2,272	2,669	1,068	1,927	1,827
78	1,929	2,326	2,743	1,097	1,984	1,886
79	1,949	2,380	2,817	1,125	2,040	1,944
80	1,970	2,435	2,887	1,156	2,096	2,003
81	1,991	2,488	2,961	1,186	2,154	2,061
82	2,012	2,543	3,035	1,214	2,210	2,121
83	2,037	2,593	3,109	1,244	2,269	2,183
84	2,063	2,642	3,182	1,273	2,330	2,248
85	2,084	2,683	3,247	1,299	2,384	2,307
86	2,105	2,726	3,316	1,325	2,440	2,369
87	2,124	2,769	3,384	1,353	2,495	2,431
88	2,146	2,812	3,454	1,381	2,553	2,496
89	2,168	2,856	3,522	1,411	2,611	2,560
90	2,187	2,898	3,592	1,437	2,668	2,622
91	2,210	2,943	3,660	1,464	2,725	2,686
92	2,232	2,985	3,728	1,492	2,782	2,749
93	2,255	3,027	3,795	1,519	2,839	2,812
94	2,276	3,067	3,863	1,545	2,894	2,875
95	2,298	3,107	3,929	1,572	2,949	2,937
96	2,321	3,147	3,994	1,597	3,003	2,997
97	2,345	3,187	4,059	1,623	3,059	3,057
98	2,369	3,227	4,123	1,649	3,111	3,118
99+	2,390	3,264	4,187	1,674	3,164	3,177

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 certificates like yours in this state. Premiums for this certificate will increase due to the increase in your age. Upon attainment of an age requiring a rate increase, the renewal premium for the certificate will be the renewal premium then in effect for your attained age. Other certificates may be provided with Issue Age rating and do not increase with age. You should compare Issue Age with Attained Age certificates.

Premiums payable other than annual 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 be covered by an Aetna Health and Life Insurance Company Medicare supplement certificate. 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 certificate 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 certificates.

READ YOUR CERTIFICATE VERY CAREFULLY

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

RIGHT TO RETURN CERTIFICATE

If you find that you are not satisfied with your certificate, you may return it to Aetna Health and Life Insurance Company, P.O. Box 1188, Brentwood, Tennessee 37024. If you send the certificate back to us within 30 days after you receive it, we will treat the certificate as if it had never been issued and return all your payments.

CERTIFICATE REPLACEMENT

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

NOTICE

The certificate 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 enrollment form for the new certificate, be sure to answer truthfully and completely any questions about your medical and health history. The company may cancel your certificate 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 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 certificate'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 certificate'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 certificate'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 $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 certificate'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 certificate'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 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.
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