Outline of coverage

Medicare Supplement Insurance

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

Missouri

Underwritten by

Aetna Health and Life Insurance Company

AetnaSeniorProducts.com

AHLMS04997MO

Rates effective: 07/2024 B

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

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

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

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2025[2]					**$7,220[2]**	**$3,610[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,870** before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

Aetna Health and Life Insurance Company

Annual Premiums

Zip Codes: 630-631, 633, 640-641

Female Rates

Rates effective 7/1/2024

ISSUE AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,727	2,811	3,913	771	2,477	2,242
65	2,139	2,614	3,190	652	2,264	2,085
66	2,156	2,632	3,213	657	2,281	2,110
67	2,190	2,677	3,268	669	2,320	2,156
68	2,236	2,735	3,338	682	2,368	2,213
69	2,292	2,800	3,418	699	2,426	2,276
70	2,349	2,872	3,503	717	2,486	2,335
71	2,407	2,944	3,593	735	2,549	2,396
72	2,468	3,017	3,685	753	2,615	2,455
73	2,529	3,093	3,774	772	2,680	2,514
74	2,595	3,175	3,874	792	2,750	2,576
75	2,660	3,254	3,969	811	2,819	2,641
76	2,726	3,332	4,068	832	2,886	2,703
77	2,794	3,417	4,172	852	2,959	2,769
78	2,859	3,498	4,269	872	3,028	2,837
79	2,922	3,575	4,362	892	3,095	2,900
80	2,992	3,657	4,463	912	3,165	2,968
81	3,060	3,741	4,567	933	3,240	3,037
82	3,125	3,824	4,664	954	3,310	3,104
83	3,198	3,909	4,773	976	3,387	3,174
84	3,267	3,993	4,878	996	3,460	3,242
85	3,359	4,109	5,016	1,025	3,558	3,335
86	3,432	4,196	5,122	1,046	3,634	3,406
87	3,503	4,285	5,228	1,070	3,712	3,476
88	3,576	4,372	5,337	1,091	3,788	3,550
89	3,651	4,463	5,448	1,114	3,864	3,622
90	3,725	4,555	5,560	1,136	3,944	3,695
91	3,799	4,645	5,668	1,158	4,023	3,770
92	3,872	4,734	5,780	1,182	4,101	3,844
93	3,947	4,824	5,888	1,204	4,181	3,917
94	4,019	4,912	5,998	1,225	4,256	3,988
95	4,087	4,996	6,102	1,247	4,329	4,056
96	4,150	5,075	6,195	1,266	4,396	4,122
97	4,206	5,143	6,280	1,282	4,454	4,174
98	4,252	5,196	6,344	1,297	4,500	4,218
99+	4,275	5,227	6,383	1,305	4,528	4,244

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,031	3,124	4,349	856	2,753	2,490
65	2,376	2,902	3,544	725	2,513	2,316
66	2,396	2,927	3,572	730	2,537	2,343
67	2,434	2,976	3,632	743	2,576	2,393
68	2,484	3,040	3,708	757	2,631	2,457
69	2,547	3,110	3,800	777	2,695	2,528
70	2,612	3,191	3,894	796	2,764	2,596
71	2,675	3,270	3,992	815	2,834	2,661
72	2,742	3,353	4,095	837	2,904	2,729
73	2,809	3,435	4,194	857	2,978	2,793
74	2,885	3,528	4,303	879	3,054	2,863
75	2,956	3,616	4,412	902	3,132	2,932
76	3,028	3,703	4,519	924	3,207	3,002
77	3,106	3,798	4,635	948	3,287	3,077
78	3,177	3,885	4,743	970	3,364	3,151
79	3,248	3,972	4,846	990	3,440	3,220
80	3,323	4,063	4,959	1,014	3,518	3,297
81	3,401	4,159	5,075	1,037	3,603	3,373
82	3,474	4,247	5,184	1,061	3,679	3,446
83	3,555	4,346	5,303	1,084	3,763	3,528
84	3,631	4,437	5,417	1,107	3,844	3,603
85	3,734	4,566	5,574	1,139	3,951	3,706
86	3,812	4,661	5,690	1,163	4,039	3,784
87	3,894	4,759	5,811	1,188	4,124	3,864
88	3,974	4,861	5,930	1,212	4,209	3,944
89	4,056	4,959	6,055	1,238	4,294	4,024
90	4,138	5,059	6,177	1,261	4,380	4,105
91	4,220	5,159	6,298	1,288	4,471	4,189
92	4,302	5,263	6,422	1,313	4,557	4,272
93	4,383	5,361	6,543	1,337	4,644	4,351
94	4,464	5,458	6,665	1,362	4,729	4,431
95	4,540	5,550	6,778	1,384	4,807	4,506
96	4,611	5,639	6,885	1,407	4,885	4,579
97	4,674	5,716	6,976	1,426	4,949	4,639
98	4,722	5,775	7,048	1,440	5,001	4,685
99+	4,751	5,808	7,091	1,449	5,031	4,713

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

To calculate a 7% household discount:

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

Modal premium **x** discount (.93)**= discounted premium**

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

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly.....0.0833

Aetna Health and Life Insurance Company

Annual Premiums

Zip Codes: 630-631, 633, 640-641

Male Rates

Rates effective 7/1/2024

ISSUE AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,137	3,232	4,500	886	2,849	2,577
65	2,458	3,004	3,667	750	2,603	2,397
66	2,479	3,027	3,695	755	2,623	2,426
67	2,519	3,080	3,758	768	2,664	2,479
68	2,569	3,144	3,836	785	2,722	2,542
69	2,635	3,220	3,932	804	2,790	2,617
70	2,703	3,302	4,030	823	2,859	2,687
71	2,770	3,386	4,132	844	2,931	2,755
72	2,838	3,471	4,238	866	3,006	2,824
73	2,906	3,558	4,342	887	3,080	2,894
74	2,985	3,652	4,453	911	3,161	2,966
75	3,060	3,741	4,566	933	3,240	3,036
76	3,134	3,833	4,678	956	3,321	3,108
77	3,213	3,931	4,799	980	3,403	3,185
78	3,287	4,023	4,909	1,005	3,484	3,261
79	3,359	4,110	5,016	1,025	3,559	3,333
80	3,440	4,204	5,133	1,048	3,640	3,413
81	3,519	4,301	5,252	1,074	3,726	3,491
82	3,594	4,396	5,364	1,096	3,806	3,567
83	3,678	4,498	5,490	1,122	3,893	3,649
84	3,755	4,594	5,607	1,146	3,977	3,728
85	3,864	4,725	5,767	1,179	4,092	3,836
86	3,947	4,824	5,889	1,203	4,181	3,917
87	4,030	4,927	6,012	1,230	4,269	3,998
88	4,112	5,029	6,139	1,254	4,357	4,081
89	4,200	5,133	6,266	1,280	4,445	4,165
90	4,285	5,236	6,392	1,306	4,535	4,248
91	4,367	5,341	6,518	1,332	4,627	4,336
92	4,452	5,444	6,647	1,359	4,717	4,421
93	4,538	5,547	6,772	1,384	4,806	4,504
94	4,623	5,652	6,896	1,410	4,894	4,585
95	4,702	5,749	7,013	1,434	4,978	4,666
96	4,773	5,836	7,124	1,455	5,057	4,736
97	4,837	5,915	7,220	1,475	5,124	4,801
98	4,885	5,976	7,293	1,491	5,177	4,851
99+	4,918	6,011	7,337	1,500	5,207	4,880

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,487	3,592	5,002	984	3,166	2,864
65	2,731	3,339	4,075	833	2,893	2,662
66	2,752	3,362	4,108	840	2,915	2,696
67	2,799	3,420	4,178	855	2,962	2,754
68	2,857	3,494	4,264	870	3,025	2,827
69	2,929	3,577	4,368	894	3,101	2,908
70	3,002	3,668	4,479	916	3,179	2,986
71	3,077	3,761	4,593	937	3,258	3,061
72	3,156	3,857	4,710	962	3,341	3,137
73	3,232	3,951	4,823	986	3,424	3,212
74	3,319	4,057	4,952	1,012	3,512	3,295
75	3,400	4,159	5,074	1,036	3,603	3,373
76	3,484	4,257	5,200	1,063	3,688	3,455
77	3,572	4,366	5,329	1,089	3,781	3,539
78	3,655	4,468	5,453	1,116	3,868	3,623
79	3,735	4,570	5,574	1,139	3,957	3,705
80	3,820	4,672	5,702	1,165	4,047	3,790
81	3,909	4,780	5,836	1,193	4,141	3,879
82	3,993	4,883	5,963	1,219	4,229	3,964
83	4,087	4,996	6,098	1,247	4,328	4,056
84	4,175	5,105	6,231	1,272	4,421	4,142
85	4,291	5,251	6,411	1,310	4,547	4,262
86	4,383	5,361	6,543	1,337	4,642	4,351
87	4,479	5,475	6,682	1,366	4,743	4,444
88	4,571	5,588	6,821	1,393	4,840	4,535
89	4,664	5,702	6,963	1,422	4,938	4,628
90	4,759	5,820	7,102	1,450	5,038	4,722
91	4,854	5,933	7,242	1,481	5,142	4,816
92	4,950	6,050	7,383	1,509	5,244	4,911
93	5,042	6,166	7,525	1,539	5,341	5,004
94	5,135	6,279	7,665	1,566	5,439	5,096
95	5,220	6,385	7,794	1,593	5,531	5,181
96	5,303	6,486	7,916	1,617	5,618	5,264
97	5,373	6,574	8,023	1,640	5,693	5,335
98	5,430	6,642	8,105	1,656	5,751	5,389
99+	5,464	6,679	8,155	1,667	5,786	5,422

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

To calculate a 7% household discount:

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

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

Modal factors

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

Aetna Health and Life Insurance Company
Annual Premiums
Zip Codes: Rest of State
Female Rates

Rates effective 7/1/2024

ISSUE AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,435	2,510	3,494	688	2,212	2,002
65	1,910	2,334	2,848	582	2,021	1,862
66	1,925	2,350	2,869	587	2,037	1,884
67	1,955	2,390	2,918	597	2,071	1,925
68	1,996	2,442	2,980	609	2,114	1,976
69	2,046	2,500	3,052	624	2,166	2,032
70	2,097	2,564	3,128	640	2,220	2,085
71	2,149	2,629	3,208	656	2,276	2,139
72	2,204	2,694	3,290	672	2,335	2,192
73	2,258	2,762	3,370	689	2,393	2,245
74	2,317	2,835	3,459	707	2,455	2,300
75	2,375	2,905	3,544	724	2,517	2,358
76	2,434	2,975	3,632	743	2,577	2,413
77	2,495	3,051	3,725	761	2,642	2,472
78	2,553	3,123	3,812	779	2,704	2,533
79	2,609	3,192	3,895	796	2,763	2,589
80	2,671	3,265	3,985	814	2,826	2,650
81	2,732	3,340	4,078	833	2,893	2,712
82	2,790	3,414	4,164	852	2,955	2,771
83	2,855	3,490	4,262	871	3,024	2,834
84	2,917	3,565	4,355	889	3,089	2,895
85	2,999	3,669	4,479	915	3,177	2,978
86	3,064	3,746	4,573	934	3,245	3,041
87	3,128	3,826	4,668	955	3,314	3,104
88	3,193	3,904	4,765	974	3,382	3,170
89	3,260	3,985	4,864	995	3,450	3,234
90	3,326	4,067	4,964	1,014	3,521	3,299
91	3,392	4,147	5,061	1,034	3,592	3,366
92	3,457	4,227	5,161	1,055	3,662	3,432
93	3,524	4,307	5,257	1,075	3,733	3,497
94	3,588	4,386	5,355	1,094	3,800	3,561
95	3,649	4,461	5,448	1,113	3,865	3,621
96	3,705	4,531	5,531	1,130	3,925	3,680
97	3,755	4,592	5,607	1,145	3,977	3,727
98	3,796	4,639	5,664	1,158	4,018	3,766
99+	3,817	4,667	5,699	1,165	4,043	3,789

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,706	2,789	3,883	764	2,458	2,223
65	2,121	2,591	3,164	647	2,244	2,068
66	2,139	2,613	3,189	652	2,265	2,092
67	2,173	2,657	3,243	663	2,300	2,137
68	2,218	2,714	3,311	676	2,349	2,194
69	2,274	2,777	3,393	694	2,406	2,257
70	2,332	2,849	3,477	711	2,468	2,318
71	2,388	2,920	3,564	728	2,530	2,376
72	2,448	2,994	3,656	747	2,593	2,437
73	2,508	3,067	3,745	765	2,659	2,494
74	2,576	3,150	3,842	785	2,727	2,556
75	2,639	3,229	3,939	805	2,796	2,618
76	2,704	3,306	4,035	825	2,863	2,680
77	2,773	3,391	4,138	846	2,935	2,747
78	2,837	3,469	4,235	866	3,004	2,813
79	2,900	3,546	4,327	884	3,071	2,875
80	2,967	3,628	4,428	905	3,141	2,944
81	3,037	3,713	4,531	926	3,217	3,012
82	3,102	3,792	4,629	947	3,285	3,077
83	3,174	3,880	4,735	968	3,360	3,150
84	3,242	3,962	4,837	988	3,432	3,217
85	3,334	4,077	4,977	1,017	3,528	3,309
86	3,404	4,162	5,080	1,038	3,606	3,379
87	3,477	4,249	5,188	1,061	3,682	3,450
88	3,548	4,340	5,295	1,082	3,758	3,521
89	3,621	4,428	5,406	1,105	3,834	3,593
90	3,695	4,517	5,515	1,126	3,911	3,665
91	3,768	4,606	5,623	1,150	3,992	3,740
92	3,841	4,699	5,734	1,172	4,069	3,814
93	3,913	4,787	5,842	1,194	4,146	3,885
94	3,986	4,873	5,951	1,216	4,222	3,956
95	4,054	4,955	6,052	1,236	4,292	4,023
96	4,117	5,035	6,147	1,256	4,362	4,088
97	4,173	5,104	6,229	1,273	4,419	4,142
98	4,216	5,156	6,293	1,286	4,465	4,183
99+	4,242	5,186	6,331	1,294	4,492	4,208

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

To calculate a 7% household discount:

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

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

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

Aetna Health and Life Insurance Company

Annual Premiums

Zip Codes: Rest of State

Male Rates

Rates effective 7/1/2024

ISSUE AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,801	2,886	4,018	791	2,544	2,301
65	2,195	2,682	3,274	670	2,324	2,140
66	2,213	2,703	3,299	674	2,342	2,166
67	2,249	2,750	3,355	686	2,379	2,213
68	2,294	2,807	3,425	701	2,430	2,270
69	2,353	2,875	3,511	718	2,491	2,337
70	2,413	2,948	3,598	735	2,553	2,399
71	2,473	3,023	3,689	754	2,617	2,460
72	2,534	3,099	3,784	773	2,684	2,521
73	2,595	3,177	3,877	792	2,750	2,584
74	2,665	3,261	3,976	813	2,822	2,648
75	2,732	3,340	4,077	833	2,893	2,711
76	2,798	3,422	4,177	854	2,965	2,775
77	2,869	3,510	4,285	875	3,038	2,844
78	2,935	3,592	4,383	897	3,111	2,912
79	2,999	3,670	4,479	915	3,178	2,976
80	3,071	3,754	4,583	936	3,250	3,047
81	3,142	3,840	4,689	959	3,327	3,117
82	3,209	3,925	4,789	979	3,398	3,185
83	3,284	4,016	4,902	1,002	3,476	3,258
84	3,353	4,102	5,006	1,023	3,551	3,329
85	3,450	4,219	5,149	1,053	3,654	3,425
86	3,524	4,307	5,258	1,074	3,733	3,497
87	3,598	4,399	5,368	1,098	3,812	3,570
88	3,671	4,490	5,481	1,120	3,890	3,644
89	3,750	4,583	5,595	1,143	3,969	3,719
90	3,826	4,675	5,707	1,166	4,049	3,793
91	3,899	4,769	5,820	1,189	4,131	3,871
92	3,975	4,861	5,935	1,213	4,212	3,947
93	4,052	4,953	6,046	1,236	4,291	4,021
94	4,128	5,046	6,157	1,259	4,370	4,094
95	4,198	5,133	6,262	1,280	4,445	4,166
96	4,262	5,211	6,361	1,299	4,515	4,229
97	4,319	5,281	6,446	1,317	4,575	4,287
98	4,362	5,336	6,512	1,331	4,622	4,331
99+	4,391	5,367	6,551	1,339	4,649	4,357

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,113	3,207	4,466	879	2,827	2,557
65	2,438	2,981	3,638	744	2,583	2,377
66	2,457	3,002	3,668	750	2,603	2,407
67	2,499	3,054	3,730	763	2,645	2,459
68	2,551	3,120	3,807	777	2,701	2,524
69	2,615	3,194	3,900	798	2,769	2,596
70	2,680	3,275	3,999	818	2,838	2,666
71	2,747	3,358	4,101	837	2,909	2,733
72	2,818	3,444	4,205	859	2,983	2,801
73	2,886	3,528	4,306	880	3,057	2,868
74	2,963	3,622	4,421	904	3,136	2,942
75	3,036	3,713	4,530	925	3,217	3,012
76	3,111	3,801	4,643	949	3,293	3,085
77	3,189	3,898	4,758	972	3,376	3,160
78	3,263	3,989	4,869	996	3,454	3,235
79	3,335	4,080	4,977	1,017	3,533	3,308
80	3,411	4,171	5,091	1,040	3,613	3,384
81	3,490	4,268	5,211	1,065	3,697	3,463
82	3,565	4,360	5,324	1,088	3,776	3,539
83	3,649	4,461	5,445	1,113	3,864	3,621
84	3,728	4,558	5,563	1,136	3,947	3,698
85	3,831	4,688	5,724	1,170	4,060	3,805
86	3,913	4,787	5,842	1,194	4,145	3,885
87	3,999	4,888	5,966	1,220	4,235	3,968
88	4,081	4,989	6,090	1,244	4,321	4,049
89	4,164	5,091	6,217	1,270	4,409	4,132
90	4,249	5,196	6,341	1,295	4,498	4,216
91	4,334	5,297	6,466	1,322	4,591	4,300
92	4,420	5,402	6,592	1,347	4,682	4,385
93	4,502	5,505	6,719	1,374	4,769	4,468
94	4,585	5,606	6,844	1,398	4,856	4,550
95	4,661	5,701	6,959	1,422	4,938	4,626
96	4,735	5,791	7,068	1,444	5,016	4,700
97	4,797	5,870	7,163	1,464	5,083	4,763
98	4,848	5,930	7,237	1,479	5,135	4,812
99+	4,879	5,963	7,281	1,488	5,166	4,841

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

To calculate a 7% household discount:

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

Modal premium **x** discount (.93)**= discounted premium**

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

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

PREMIUM INFORMATION

Aetna Health and Life Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state. Premiums may be changed for this policy on any premium due date, provided premiums for all policies issued on this form number in your state are also changed. For every nonscheduled premium change, we will give you at least 30 days advance notice in writing of such premium change. 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 company Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; or (b) be someone with whom you are in a civil union partnership; and (c) someone with whom you have continuously resided for the past 12 months. The household discount will only be applicable if a policy for each applicant is issued. The discounted 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 14770, Lexington, KY 40512-4770. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

POLICY REPLACEMENT

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

NOTICE

The policy may not cover all of your medical costs. Neither Aetna Health 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 BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,676	$0	$1,676 (Part A Deductible)
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	$0	Up to $209.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN A

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

*Once you have been billed $257 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-Approved amounts*	$0	$0	$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $257 of Medicare-Approved amounts*	$0	$0	$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $257 of Medicare-Approved amounts*	$0	$0	$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	$0	Up to $209.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN B

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

*Once you have been billed $257 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-Approved amounts*	$0	$0	$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $257 of Medicare-Approved amounts*	$0	$0	$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $257 of Medicare-Approved amounts*	$0	$0	$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN F

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

*Once you have been billed $257 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-Approved amounts*	$0	$257 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $257 of Medicare-Approved amounts*	$0	$257 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $257 of Medicare-Approved amounts*	$0	$257 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

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 PLAN F

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

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

****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,870 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,870. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,870 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $257 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,870 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,870. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,870 DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-Approved amounts*	$0	$257 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $257 of Medicare-Approved amounts*	$0	$257 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,870 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $257 of Medicare-Approved amounts*	$0	$257 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,870 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN G

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

*Once you have been billed $257 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-Approved amounts*	$0	$0	$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $257 of Medicare-Approved amounts*	$0	$0	$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $257 of Medicare-Approved amounts*	$0	$0	$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

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 $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN N

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

*Once you have been billed $257 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $257 of Medicare-Approved amounts*	$0	$0	$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $257 of Medicare-Approved amounts*	$0	$0	$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $257 of Medicare-Approved amounts*	$0	$0	$257 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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