Outline of coverage

Medicare Supplement Insurance

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

Illinois

Underwritten by

Aetna Health Insurance Company

AetnaSeniorProducts.com

AHCMS04869IL

Rates effective: 04/2023 A

AETNA HEALTH INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE
BENEFIT PLANS AVAILABLE: A, B, F, G, HIGH DEDUCTIBLE 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 2023[2]					**$6,940[2]**	**$3,470[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,700** before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

Aetna Health Insurance Company
Annual premiums
For use in ZIP Codes: 600-608
Female rates

Rates effective 04/1/2023

ATTAINED AGE	PREFERRED						STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	3,659	3,942	5,189	4,326	1,380	3,090	4,065	4,380	5,766	4,806	1,533	3,433
65	1,473	1,586	2,088	1,739	556	1,175	1,637	1,763	2,320	1,934	618	1,306
66	1,473	1,586	2,088	1,739	556	1,175	1,637	1,763	2,320	1,934	618	1,306
67	1,473	1,586	2,088	1,739	556	1,175	1,637	1,763	2,320	1,934	618	1,306
68	1,489	1,603	2,111	1,759	562	1,219	1,654	1,783	2,345	1,956	624	1,354
69	1,522	1,639	2,160	1,798	575	1,269	1,692	1,823	2,400	1,999	639	1,410
70	1,562	1,683	2,214	1,847	589	1,316	1,735	1,869	2,461	2,051	655	1,463
71	1,611	1,734	2,282	1,903	607	1,362	1,788	1,927	2,535	2,116	675	1,514
72	1,659	1,787	2,354	1,962	626	1,409	1,844	1,986	2,614	2,180	696	1,565
73	1,715	1,846	2,431	2,026	647	1,456	1,905	2,051	2,701	2,250	719	1,618
74	1,774	1,911	2,516	2,097	669	1,505	1,971	2,122	2,797	2,330	744	1,672
75	1,837	1,978	2,603	2,170	693	1,555	2,040	2,199	2,893	2,411	769	1,726
76	1,900	2,047	2,695	2,247	717	1,604	2,111	2,276	2,995	2,496	797	1,783
77	1,967	2,119	2,788	2,324	743	1,658	2,186	2,354	3,098	2,584	825	1,843
78	2,034	2,192	2,885	2,405	768	1,713	2,261	2,434	3,205	2,671	854	1,904
79	2,098	2,260	2,975	2,480	791	1,769	2,331	2,511	3,304	2,756	879	1,965
80	2,163	2,330	3,067	2,556	817	1,828	2,403	2,589	3,410	2,842	908	2,031
81	2,231	2,404	3,166	2,637	842	1,885	2,479	2,671	3,515	2,930	936	2,095
82	2,298	2,475	3,259	2,716	867	1,940	2,553	2,751	3,619	3,019	963	2,157
83	2,368	2,552	3,360	2,801	894	2,001	2,632	2,836	3,733	3,112	992	2,223
84	2,438	2,626	3,458	2,883	920	2,059	2,710	2,917	3,839	3,201	1,022	2,289
85	2,527	2,721	3,583	2,987	953	2,133	2,809	3,025	3,980	3,319	1,059	2,370
86	2,599	2,798	3,685	3,072	980	2,196	2,888	3,109	4,096	3,414	1,089	2,439
87	2,672	2,879	3,790	3,159	1,008	2,258	2,969	3,199	4,211	3,511	1,120	2,510
88	2,747	2,959	3,897	3,249	1,037	2,322	3,051	3,288	4,330	3,610	1,152	2,579
89	2,825	3,041	4,005	3,338	1,066	2,384	3,137	3,380	4,450	3,709	1,184	2,650
90	2,902	3,127	4,114	3,430	1,094	2,451	3,225	3,472	4,572	3,812	1,217	2,723
91	2,980	3,211	4,227	3,523	1,124	2,517	3,311	3,568	4,696	3,915	1,250	2,797
92	3,062	3,297	4,341	3,617	1,154	2,585	3,401	3,664	4,823	4,019	1,283	2,873
93	3,144	3,386	4,456	3,715	1,185	2,654	3,493	3,762	4,951	4,127	1,318	2,948
94	3,226	3,474	4,573	3,813	1,217	2,724	3,584	3,862	5,083	4,237	1,352	3,027
95	3,310	3,565	4,694	3,912	1,249	2,795	3,679	3,962	5,215	4,347	1,388	3,106
96	3,395	3,657	4,814	4,014	1,281	2,867	3,772	4,064	5,350	4,459	1,423	3,186
97	3,481	3,751	4,937	4,117	1,313	2,942	3,868	4,168	5,487	4,573	1,459	3,268
98	3,570	3,845	5,062	4,220	1,346	3,015	3,966	4,272	5,624	4,690	1,496	3,350
99+	3,659	3,942	5,189	4,326	1,380	3,090	4,065	4,380	5,766	4,806	1,533	3,433

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

To calculate the 7% household discount:

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

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

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

Aetna Health Insurance Company
Annual premiums
For use in ZIP Codes: 600-608
Male rates
Rates effective 04/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	4,208	4,532	5,967	4,975	1,586	3,553
65	1,694	1,826	2,401	2,002	639	1,352
66	1,694	1,826	2,401	2,002	639	1,352
67	1,694	1,826	2,401	2,002	639	1,352
68	1,713	1,844	2,428	2,025	646	1,401
69	1,749	1,886	2,484	2,069	662	1,460
70	1,797	1,935	2,547	2,125	678	1,515
71	1,851	1,994	2,624	2,188	698	1,567
72	1,909	2,055	2,706	2,257	720	1,621
73	1,971	2,122	2,796	2,330	744	1,676
74	2,040	2,199	2,894	2,411	769	1,732
75	2,112	2,276	2,995	2,496	797	1,788
76	2,186	2,353	3,098	2,584	825	1,845
77	2,262	2,438	3,209	2,674	854	1,907
78	2,339	2,520	3,318	2,765	884	1,968
79	2,412	2,597	3,421	2,852	910	2,034
80	2,486	2,678	3,529	2,942	939	2,102
81	2,566	2,766	3,640	3,035	969	2,167
82	2,644	2,847	3,745	3,125	997	2,232
83	2,725	2,935	3,864	3,222	1,028	2,301
84	2,802	3,020	3,976	3,313	1,058	2,369
85	2,905	3,130	4,119	3,435	1,097	2,454
86	2,988	3,218	4,238	3,533	1,127	2,525
87	3,074	3,311	4,359	3,633	1,159	2,596
88	3,159	3,402	4,481	3,735	1,192	2,670
89	3,249	3,498	4,604	3,838	1,225	2,742
90	3,337	3,594	4,733	3,945	1,259	2,818
91	3,428	3,693	4,861	4,053	1,293	2,896
92	3,521	3,792	4,992	4,161	1,328	2,974
93	3,615	3,894	5,123	4,271	1,363	3,053
94	3,710	3,996	5,259	4,383	1,399	3,132
95	3,805	4,099	5,397	4,500	1,436	3,215
96	3,903	4,206	5,537	4,615	1,473	3,297
97	4,004	4,313	5,678	4,734	1,510	3,383
98	4,105	4,422	5,822	4,853	1,548	3,467
99+	4,208	4,532	5,967	4,975	1,586	3,553

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	4,676	5,037	6,630	5,528	1,763	3,949
65	1,883	2,027	2,670	2,223	712	1,502
66	1,883	2,027	2,670	2,223	712	1,502
67	1,883	2,027	2,670	2,223	712	1,502
68	1,901	2,049	2,698	2,249	717	1,557
69	1,946	2,096	2,758	2,299	735	1,622
70	1,995	2,150	2,831	2,360	754	1,683
71	2,056	2,217	2,917	2,432	776	1,739
72	2,119	2,284	3,006	2,507	800	1,799
73	2,189	2,360	3,106	2,589	827	1,863
74	2,268	2,443	3,216	2,680	856	1,924
75	2,348	2,527	3,326	2,774	885	1,986
76	2,429	2,616	3,444	2,869	917	2,051
77	2,514	2,710	3,563	2,971	948	2,119
78	2,599	2,799	3,685	3,071	981	2,189
79	2,680	2,886	3,802	3,171	1,011	2,260
80	2,764	2,976	3,921	3,268	1,045	2,335
81	2,850	3,072	4,045	3,372	1,076	2,409
82	2,936	3,161	4,161	3,472	1,108	2,481
83	3,026	3,262	4,295	3,581	1,141	2,557
84	3,115	3,353	4,418	3,683	1,175	2,632
85	3,229	3,478	4,578	3,817	1,218	2,726
86	3,321	3,576	4,712	3,928	1,252	2,806
87	3,414	3,680	4,843	4,036	1,288	2,886
88	3,511	3,781	4,979	4,151	1,325	2,966
89	3,608	3,886	5,117	4,266	1,362	3,048
90	3,709	3,995	5,258	4,382	1,399	3,130
91	3,808	4,104	5,401	4,502	1,437	3,217
92	3,912	4,212	5,548	4,623	1,475	3,304
93	4,016	4,326	5,694	4,746	1,515	3,391
94	4,121	4,441	5,845	4,873	1,555	3,481
95	4,230	4,555	5,997	4,998	1,596	3,572
96	4,338	4,673	6,152	5,128	1,636	3,664
97	4,448	4,794	6,309	5,260	1,677	3,758
98	4,561	4,915	6,467	5,392	1,721	3,853
99+	4,676	5,037	6,630	5,528	1,763	3,949

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

To calculate the 7% household discount:

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

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

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

Aetna Health Insurance Company

Annual premiums

For use in: Rest of State

Female rates

Rates effective 04/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	3,296	3,551	4,675	3,897	1,243	2,784
65	1,327	1,429	1,881	1,567	501	1,059
66	1,327	1,429	1,881	1,567	501	1,059
67	1,327	1,429	1,881	1,567	501	1,059
68	1,341	1,444	1,902	1,585	506	1,098
69	1,371	1,477	1,946	1,620	518	1,143
70	1,407	1,516	1,995	1,664	531	1,186
71	1,451	1,562	2,056	1,714	547	1,227
72	1,495	1,610	2,121	1,768	564	1,269
73	1,545	1,663	2,190	1,825	583	1,312
74	1,598	1,722	2,267	1,889	603	1,356
75	1,655	1,782	2,345	1,955	624	1,401
76	1,712	1,844	2,428	2,024	646	1,445
77	1,772	1,909	2,512	2,094	669	1,494
78	1,832	1,975	2,599	2,167	692	1,543
79	1,890	2,036	2,680	2,234	713	1,594
80	1,949	2,099	2,763	2,303	736	1,647
81	2,010	2,166	2,852	2,376	759	1,698
82	2,070	2,230	2,936	2,447	781	1,748
83	2,133	2,299	3,027	2,523	805	1,803
84	2,196	2,366	3,115	2,597	829	1,855
85	2,277	2,451	3,228	2,691	859	1,922
86	2,341	2,521	3,320	2,768	883	1,978
87	2,407	2,594	3,414	2,846	908	2,034
88	2,475	2,666	3,511	2,927	934	2,092
89	2,545	2,740	3,608	3,007	960	2,148
90	2,614	2,817	3,706	3,090	986	2,208
91	2,685	2,893	3,808	3,174	1,013	2,268
92	2,759	2,970	3,911	3,259	1,040	2,329
93	2,832	3,050	4,014	3,347	1,068	2,391
94	2,906	3,130	4,120	3,435	1,096	2,454
95	2,982	3,212	4,229	3,524	1,125	2,518
96	3,059	3,295	4,337	3,616	1,154	2,583
97	3,136	3,379	4,448	3,709	1,183	2,650
98	3,216	3,464	4,560	3,802	1,213	2,716
99+	3,296	3,551	4,675	3,897	1,243	2,784

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	3,662	3,946	5,195	4,330	1,381	3,093
65	1,475	1,588	2,090	1,742	557	1,177
66	1,475	1,588	2,090	1,742	557	1,177
67	1,475	1,588	2,090	1,742	557	1,177
68	1,490	1,606	2,113	1,762	562	1,220
69	1,524	1,642	2,162	1,801	576	1,270
70	1,563	1,684	2,217	1,848	590	1,318
71	1,611	1,736	2,284	1,906	608	1,364
72	1,661	1,789	2,355	1,964	627	1,410
73	1,716	1,848	2,433	2,027	648	1,458
74	1,776	1,912	2,520	2,099	670	1,506
75	1,838	1,981	2,606	2,172	693	1,555
76	1,902	2,050	2,698	2,249	718	1,606
77	1,969	2,121	2,791	2,328	743	1,660
78	2,037	2,193	2,887	2,406	769	1,715
79	2,100	2,262	2,977	2,483	792	1,770
80	2,165	2,332	3,072	2,560	818	1,830
81	2,233	2,406	3,167	2,640	843	1,887
82	2,300	2,478	3,260	2,720	868	1,943
83	2,371	2,555	3,363	2,804	894	2,003
84	2,441	2,628	3,459	2,884	921	2,062
85	2,531	2,725	3,586	2,990	954	2,135
86	2,602	2,801	3,690	3,076	981	2,197
87	2,675	2,882	3,794	3,163	1,009	2,261
88	2,749	2,962	3,901	3,252	1,038	2,323
89	2,826	3,045	4,009	3,341	1,067	2,387
90	2,905	3,128	4,119	3,434	1,096	2,453
91	2,983	3,214	4,231	3,527	1,126	2,520
92	3,064	3,301	4,345	3,621	1,156	2,588
93	3,147	3,389	4,460	3,718	1,187	2,656
94	3,229	3,479	4,579	3,817	1,218	2,727
95	3,314	3,569	4,698	3,916	1,250	2,798
96	3,398	3,661	4,820	4,017	1,282	2,870
97	3,485	3,755	4,943	4,120	1,314	2,944
98	3,573	3,849	5,067	4,225	1,348	3,018
99+	3,662	3,946	5,195	4,330	1,381	3,093

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

To calculate the 7% household discount:

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

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

Aetna Health Insurance Company
Annual premiums
For use in: Rest of State
Male rates
Rates effective 04/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	3,791	4,083	5,376	4,482	1,429	3,201
65	1,526	1,645	2,163	1,804	576	1,218
66	1,526	1,645	2,163	1,804	576	1,218
67	1,526	1,645	2,163	1,804	576	1,218
68	1,543	1,661	2,187	1,824	582	1,262
69	1,576	1,699	2,238	1,864	596	1,315
70	1,619	1,743	2,295	1,914	611	1,365
71	1,668	1,796	2,364	1,971	629	1,412
72	1,720	1,851	2,438	2,033	649	1,460
73	1,776	1,912	2,519	2,099	670	1,510
74	1,838	1,981	2,607	2,172	693	1,560
75	1,903	2,050	2,698	2,249	718	1,611
76	1,969	2,120	2,791	2,328	743	1,662
77	2,038	2,196	2,891	2,409	769	1,718
78	2,107	2,270	2,989	2,491	796	1,773
79	2,173	2,340	3,082	2,569	820	1,832
80	2,240	2,413	3,179	2,650	846	1,894
81	2,312	2,492	3,279	2,734	873	1,952
82	2,382	2,565	3,374	2,815	898	2,011
83	2,455	2,644	3,481	2,903	926	2,073
84	2,524	2,721	3,582	2,985	953	2,134
85	2,617	2,820	3,711	3,095	988	2,211
86	2,692	2,899	3,818	3,183	1,015	2,275
87	2,769	2,983	3,927	3,273	1,044	2,339
88	2,846	3,065	4,037	3,365	1,074	2,405
89	2,927	3,151	4,148	3,458	1,104	2,470
90	3,006	3,238	4,264	3,554	1,134	2,539
91	3,088	3,327	4,379	3,651	1,165	2,609
92	3,172	3,416	4,497	3,749	1,196	2,679
93	3,257	3,508	4,615	3,848	1,228	2,750
94	3,342	3,600	4,738	3,949	1,260	2,822
95	3,428	3,693	4,862	4,054	1,294	2,896
96	3,516	3,789	4,988	4,158	1,327	2,970
97	3,607	3,886	5,115	4,265	1,360	3,048
98	3,698	3,984	5,245	4,372	1,395	3,123
99+	3,791	4,083	5,376	4,482	1,429	3,201

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	4,213	4,538	5,973	4,980	1,588	3,558
65	1,696	1,826	2,405	2,003	641	1,353
66	1,696	1,826	2,405	2,003	641	1,353
67	1,696	1,826	2,405	2,003	641	1,353
68	1,713	1,846	2,431	2,026	646	1,403
69	1,753	1,888	2,485	2,071	662	1,461
70	1,797	1,937	2,550	2,126	679	1,516
71	1,852	1,997	2,628	2,191	699	1,567
72	1,909	2,058	2,708	2,259	721	1,621
73	1,972	2,126	2,798	2,332	745	1,678
74	2,043	2,201	2,897	2,414	771	1,733
75	2,115	2,277	2,996	2,499	797	1,789
76	2,188	2,357	3,103	2,585	826	1,848
77	2,265	2,441	3,210	2,677	854	1,909
78	2,341	2,522	3,320	2,767	884	1,972
79	2,414	2,600	3,425	2,857	911	2,036
80	2,490	2,681	3,532	2,944	941	2,104
81	2,568	2,768	3,644	3,038	969	2,170
82	2,645	2,848	3,749	3,128	998	2,235
83	2,726	2,939	3,869	3,226	1,028	2,304
84	2,806	3,021	3,980	3,318	1,059	2,371
85	2,909	3,133	4,124	3,439	1,097	2,456
86	2,992	3,222	4,245	3,539	1,128	2,528
87	3,076	3,315	4,363	3,636	1,160	2,600
88	3,163	3,406	4,486	3,740	1,194	2,672
89	3,250	3,501	4,610	3,843	1,227	2,746
90	3,341	3,599	4,737	3,948	1,260	2,820
91	3,431	3,697	4,866	4,056	1,295	2,898
92	3,524	3,795	4,998	4,165	1,329	2,977
93	3,618	3,897	5,130	4,276	1,365	3,055
94	3,713	4,001	5,266	4,390	1,401	3,136
95	3,811	4,104	5,403	4,503	1,438	3,218
96	3,908	4,210	5,542	4,620	1,474	3,301
97	4,007	4,319	5,684	4,739	1,511	3,386
98	4,109	4,428	5,826	4,858	1,550	3,471
99+	4,213	4,538	5,973	4,980	1,588	3,558

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

To calculate the 7% household discount:

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

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

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

PREMIUM INFORMATION

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

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

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

HOUSEHOLD DISCOUNT

In order to be eligible for the Household discount under an Aetna Health Insurance Company Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently have a Medicare supplement policy with an Aetna company. The Medicare eligible adult must be either (a) your spouse or someone with whom you are in a civil union partnership; and (b) someone with whom you have continuously resided for the past 12 months. The household discount will only be applicable if apolicy foreach applicant is issued. The discounted rates will be 7 percent lower than the individual rates and will apply as long as both policies remain in force.

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Aetna Health Insurance Company, P.O. Box 14770, Lexington, Kentucky 40512-4770. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

POLICY REPLACEMENT

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

NOTICE

The policy may not cover all of your medical costs. Neither Aetna Health Insurance Company nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare & You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the 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, G, HIGH DEDUCTIBLE G and N OFFERED BY AETNA HEALTH INSURANCE COMPANY.

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,600	$0	$1,600 (Part A Deductible)
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	$0	Up to $200 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 $226 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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $1,600	$1,600 (Part A Deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	$0	Up to $200 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 $226 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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $1,600	$1,600 (Part A Deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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 $226 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 $226 of Medicare-Approved amounts*	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$226 (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

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 $1,600	$1,600 (Part A Deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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 $226 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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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

HIGH DEDUCTIBLE 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.

****This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,700 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are $2,700. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,700 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,700 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,600	$1,600 (Part A Deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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 G

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

*Once you have been billed $226 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 G after one has paid a calendar year $2,700 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are $2,700. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,700 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,700 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 $226 of Medicare-Approved amounts*	$0	$0	$226 (Unless Part B Deductible has been met)
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 $226 of Medicare-Approved amounts*	$0	$0	$226 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,700 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,700 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $226 of Medicare-Approved amounts*	$0	$0	$226 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,700 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,700 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 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 $1,600	$1,600 (Part A Deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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 $226 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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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