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: 04/2025 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 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 Insurance Company
Annual premiums
For use in ZIP Codes: 600-608
Female rates

Rates effective 04/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	5,259	5,667	7,459	6,219	1,380	4,443
65	2,118	2,280	3,001	2,501	556	1,691
66	2,118	2,280	3,001	2,501	556	1,691
67	2,118	2,280	3,001	2,501	556	1,691
68	2,140	2,304	3,035	2,530	562	1,753
69	2,188	2,358	3,106	2,585	575	1,824
70	2,246	2,419	3,183	2,656	589	1,893
71	2,315	2,492	3,280	2,735	607	1,958
72	2,385	2,570	3,384	2,821	626	2,025
73	2,465	2,653	3,495	2,913	647	2,093
74	2,551	2,747	3,617	3,014	669	2,163
75	2,641	2,843	3,742	3,119	693	2,236
76	2,732	2,943	3,874	3,230	717	2,307
77	2,828	3,046	4,008	3,341	743	2,384
78	2,924	3,151	4,147	3,458	768	2,462
79	3,017	3,248	4,277	3,564	791	2,543
80	3,109	3,350	4,408	3,674	817	2,628
81	3,208	3,457	4,551	3,791	842	2,710
82	3,303	3,559	4,684	3,905	867	2,789
83	3,403	3,669	4,830	4,025	894	2,876
84	3,503	3,775	4,971	4,145	920	2,959
85	3,634	3,912	5,150	4,295	953	3,067
86	3,735	4,023	5,298	4,417	980	3,157
87	3,841	4,139	5,448	4,541	1,008	3,246
88	3,949	4,255	5,603	4,671	1,037	3,339
89	4,061	4,372	5,756	4,799	1,066	3,428
90	4,171	4,496	5,914	4,932	1,094	3,523
91	4,285	4,616	6,076	5,065	1,124	3,619
92	4,402	4,740	6,242	5,200	1,154	3,716
93	4,519	4,867	6,405	5,340	1,185	3,816
94	4,638	4,995	6,575	5,481	1,217	3,916
95	4,757	5,126	6,748	5,623	1,249	4,018
96	4,882	5,257	6,921	5,770	1,281	4,121
97	5,004	5,392	7,097	5,917	1,313	4,229
98	5,132	5,528	7,276	6,066	1,346	4,333
99+	5,259	5,667	7,459	6,219	1,380	4,443

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	5,843	6,297	8,289	6,910	1,533	4,935
65	2,353	2,534	3,336	2,779	618	1,879
66	2,353	2,534	3,336	2,779	618	1,879
67	2,353	2,534	3,336	2,779	618	1,879
68	2,379	2,563	3,372	2,812	624	1,947
69	2,432	2,620	3,450	2,874	639	2,027
70	2,493	2,687	3,539	2,948	655	2,103
71	2,571	2,769	3,645	3,041	675	2,177
72	2,651	2,854	3,757	3,135	696	2,251
73	2,737	2,948	3,883	3,235	719	2,327
74	2,834	3,051	4,022	3,350	744	2,403
75	2,934	3,161	4,158	3,467	769	2,481
76	3,035	3,272	4,306	3,589	797	2,563
77	3,141	3,384	4,454	3,714	825	2,648
78	3,251	3,500	4,607	3,839	854	2,736
79	3,351	3,609	4,751	3,962	879	2,825
80	3,455	3,722	4,902	4,085	908	2,920
81	3,563	3,839	5,054	4,212	936	3,011
82	3,670	3,955	5,201	4,340	963	3,100
83	3,784	4,077	5,366	4,474	992	3,196
84	3,895	4,194	5,520	4,602	1,022	3,290
85	4,039	4,349	5,722	4,772	1,059	3,407
86	4,151	4,469	5,889	4,907	1,089	3,506
87	4,268	4,599	6,054	5,046	1,120	3,608
88	4,386	4,726	6,225	5,189	1,152	3,706
89	4,510	4,860	6,397	5,331	1,184	3,808
90	4,635	4,991	6,572	5,479	1,217	3,914
91	4,760	5,128	6,752	5,628	1,250	4,022
92	4,890	5,267	6,933	5,778	1,283	4,129
93	5,022	5,407	7,116	5,933	1,318	4,238
94	5,152	5,551	7,307	6,092	1,352	4,351
95	5,288	5,694	7,497	6,248	1,388	4,466
96	5,422	5,842	7,691	6,410	1,423	4,580
97	5,561	5,992	7,887	6,575	1,459	4,699
98	5,701	6,142	8,085	6,742	1,496	4,816
99+	5,843	6,297	8,289	6,910	1,533	4,935

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 04/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	6,050	6,515	8,578	7,152	1,586	5,107
65	2,435	2,625	3,451	2,879	639	1,944
66	2,435	2,625	3,451	2,879	639	1,944
67	2,435	2,625	3,451	2,879	639	1,944
68	2,462	2,651	3,490	2,912	646	2,014
69	2,514	2,712	3,572	2,975	662	2,098
70	2,584	2,781	3,662	3,054	678	2,179
71	2,662	2,865	3,773	3,146	698	2,253
72	2,745	2,954	3,891	3,245	720	2,330
73	2,834	3,051	4,019	3,350	744	2,410
74	2,934	3,161	4,160	3,467	769	2,490
75	3,036	3,272	4,306	3,589	797	2,571
76	3,141	3,383	4,454	3,714	825	2,652
77	3,252	3,503	4,613	3,844	854	2,742
78	3,362	3,623	4,769	3,975	884	2,829
79	3,468	3,734	4,917	4,099	910	2,924
80	3,574	3,851	5,073	4,229	939	3,023
81	3,690	3,977	5,233	4,362	969	3,115
82	3,801	4,094	5,384	4,491	997	3,209
83	3,917	4,219	5,554	4,632	1,028	3,308
84	4,028	4,341	5,715	4,763	1,058	3,405
85	4,177	4,500	5,922	4,938	1,097	3,529
86	4,296	4,626	6,093	5,078	1,127	3,630
87	4,418	4,760	6,266	5,223	1,159	3,733
88	4,541	4,891	6,442	5,370	1,192	3,838
89	4,671	5,028	6,619	5,518	1,225	3,942
90	4,796	5,167	6,804	5,671	1,259	4,052
91	4,927	5,309	6,987	5,826	1,293	4,163
92	5,062	5,450	7,176	5,982	1,328	4,275
93	5,198	5,598	7,364	6,139	1,363	4,389
94	5,332	5,744	7,560	6,300	1,399	4,502
95	5,470	5,893	7,758	6,469	1,436	4,621
96	5,610	6,045	7,959	6,636	1,473	4,740
97	5,755	6,200	8,162	6,805	1,510	4,863
98	5,901	6,358	8,369	6,976	1,548	4,983
99+	6,050	6,515	8,578	7,152	1,586	5,107

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	6,722	7,242	9,530	7,946	1,763	5,678
65	2,706	2,914	3,838	3,196	712	2,159
66	2,706	2,914	3,838	3,196	712	2,159
67	2,706	2,914	3,838	3,196	712	2,159
68	2,734	2,946	3,879	3,233	717	2,238
69	2,797	3,013	3,966	3,306	735	2,331
70	2,868	3,091	4,069	3,392	754	2,419
71	2,956	3,187	4,194	3,497	776	2,501
72	3,046	3,284	4,321	3,605	800	2,586
73	3,147	3,392	4,466	3,722	827	2,678
74	3,259	3,512	4,623	3,852	856	2,765
75	3,374	3,634	4,780	3,988	885	2,854
76	3,491	3,762	4,951	4,125	917	2,948
77	3,614	3,895	5,123	4,272	948	3,046
78	3,735	4,024	5,298	4,416	981	3,147
79	3,852	4,149	5,466	4,560	1,011	3,248
80	3,974	4,278	5,637	4,699	1,045	3,358
81	4,097	4,417	5,815	4,848	1,076	3,463
82	4,221	4,544	5,982	4,991	1,108	3,566
83	4,350	4,690	6,173	5,148	1,141	3,677
84	4,478	4,821	6,350	5,295	1,175	3,784
85	4,641	4,999	6,581	5,488	1,218	3,918
86	4,774	5,140	6,774	5,648	1,252	4,034
87	4,907	5,289	6,961	5,801	1,288	4,149
88	5,046	5,435	7,158	5,967	1,325	4,264
89	5,187	5,587	7,357	6,132	1,362	4,382
90	5,331	5,743	7,559	6,299	1,399	4,500
91	5,476	5,900	7,764	6,471	1,437	4,624
92	5,623	6,055	7,975	6,647	1,475	4,751
93	5,773	6,219	8,186	6,822	1,515	4,874
94	5,925	6,384	8,403	7,005	1,555	5,004
95	6,082	6,549	8,620	7,185	1,596	5,135
96	6,236	6,719	8,842	7,372	1,636	5,267
97	6,394	6,892	9,070	7,562	1,677	5,403
98	6,556	7,065	9,296	7,752	1,721	5,539
99+	6,722	7,242	9,530	7,946	1,763	5,678

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 04/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	4,738	5,105	6,720	5,603	1,243	4,003
65	1,908	2,054	2,704	2,253	501	1,523
66	1,908	2,054	2,704	2,253	501	1,523
67	1,908	2,054	2,704	2,253	501	1,523
68	1,928	2,076	2,734	2,279	506	1,579
69	1,971	2,124	2,798	2,329	518	1,643
70	2,023	2,179	2,868	2,393	531	1,705
71	2,086	2,245	2,955	2,464	547	1,764
72	2,149	2,315	3,049	2,541	564	1,824
73	2,221	2,390	3,149	2,624	583	1,886
74	2,298	2,475	3,259	2,715	603	1,949
75	2,379	2,561	3,371	2,810	624	2,014
76	2,461	2,651	3,490	2,910	646	2,078
77	2,548	2,744	3,611	3,010	669	2,148
78	2,634	2,839	3,736	3,115	692	2,218
79	2,718	2,926	3,853	3,211	713	2,291
80	2,801	3,018	3,971	3,310	736	2,368
81	2,890	3,114	4,100	3,415	759	2,441
82	2,976	3,206	4,220	3,518	781	2,513
83	3,066	3,305	4,351	3,626	805	2,591
84	3,156	3,401	4,478	3,734	829	2,666
85	3,274	3,524	4,640	3,869	859	2,763
86	3,365	3,624	4,773	3,979	883	2,844
87	3,460	3,729	4,908	4,091	908	2,924
88	3,558	3,833	5,048	4,208	934	3,008
89	3,659	3,939	5,186	4,323	960	3,088
90	3,758	4,050	5,328	4,443	986	3,174
91	3,860	4,159	5,474	4,563	1,013	3,260
92	3,966	4,270	5,623	4,685	1,040	3,348
93	4,071	4,385	5,770	4,811	1,068	3,438
94	4,178	4,500	5,923	4,938	1,096	3,528
95	4,286	4,618	6,079	5,066	1,125	3,620
96	4,398	4,736	6,235	5,198	1,154	3,713
97	4,508	4,858	6,394	5,331	1,183	3,810
98	4,623	4,980	6,555	5,465	1,213	3,904
99+	4,738	5,105	6,720	5,603	1,243	4,003

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	5,264	5,673	7,468	6,225	1,381	4,446
65	2,120	2,283	3,005	2,504	557	1,693
66	2,120	2,283	3,005	2,504	557	1,693
67	2,120	2,283	3,005	2,504	557	1,693
68	2,143	2,309	3,038	2,533	562	1,754
69	2,191	2,360	3,108	2,589	576	1,826
70	2,246	2,421	3,188	2,656	590	1,895
71	2,316	2,495	3,284	2,740	608	1,961
72	2,388	2,571	3,385	2,824	627	2,028
73	2,466	2,656	3,498	2,914	648	2,096
74	2,553	2,749	3,623	3,018	670	2,165
75	2,643	2,848	3,746	3,123	693	2,235
76	2,734	2,948	3,879	3,233	718	2,309
77	2,830	3,049	4,013	3,346	743	2,386
78	2,929	3,153	4,150	3,459	769	2,465
79	3,019	3,251	4,280	3,569	792	2,545
80	3,113	3,353	4,416	3,680	818	2,631
81	3,210	3,459	4,553	3,795	843	2,713
82	3,306	3,563	4,686	3,910	868	2,793
83	3,409	3,673	4,834	4,031	894	2,879
84	3,509	3,778	4,973	4,146	921	2,964
85	3,639	3,918	5,155	4,299	954	3,069
86	3,740	4,026	5,305	4,421	981	3,159
87	3,845	4,143	5,454	4,546	1,009	3,250
88	3,951	4,258	5,608	4,675	1,038	3,339
89	4,063	4,378	5,763	4,803	1,067	3,431
90	4,176	4,496	5,921	4,936	1,096	3,526
91	4,288	4,620	6,083	5,070	1,126	3,623
92	4,405	4,745	6,246	5,205	1,156	3,720
93	4,524	4,871	6,411	5,345	1,187	3,818
94	4,641	5,001	6,583	5,488	1,218	3,920
95	4,764	5,130	6,754	5,629	1,250	4,023
96	4,885	5,263	6,929	5,775	1,282	4,126
97	5,010	5,398	7,105	5,923	1,314	4,233
98	5,136	5,533	7,284	6,074	1,348	4,339
99+	5,264	5,673	7,468	6,225	1,381	4,446

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
Male rates
Rates effective 04/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	5,450	5,869	7,728	6,443	1,429	4,601
65	2,194	2,365	3,109	2,594	576	1,751
66	2,194	2,365	3,109	2,594	576	1,751
67	2,194	2,365	3,109	2,594	576	1,751
68	2,218	2,388	3,144	2,623	582	1,814
69	2,265	2,443	3,218	2,680	596	1,890
70	2,328	2,505	3,299	2,751	611	1,963
71	2,398	2,581	3,399	2,834	629	2,030
72	2,473	2,661	3,505	2,923	649	2,099
73	2,553	2,749	3,621	3,018	670	2,171
74	2,643	2,848	3,748	3,123	693	2,243
75	2,735	2,948	3,879	3,233	718	2,316
76	2,830	3,048	4,013	3,346	743	2,389
77	2,930	3,156	4,156	3,463	769	2,470
78	3,029	3,264	4,296	3,581	796	2,549
79	3,124	3,364	4,430	3,693	820	2,634
80	3,220	3,469	4,570	3,810	846	2,723
81	3,324	3,583	4,714	3,930	873	2,806
82	3,424	3,688	4,850	4,046	898	2,891
83	3,529	3,801	5,004	4,173	926	2,980
84	3,629	3,911	5,149	4,291	953	3,068
85	3,763	4,054	5,335	4,449	988	3,179
86	3,870	4,168	5,489	4,575	1,015	3,270
87	3,980	4,288	5,645	4,705	1,044	3,363
88	4,091	4,406	5,804	4,838	1,074	3,458
89	4,208	4,530	5,963	4,971	1,104	3,551
90	4,321	4,655	6,130	5,109	1,134	3,650
91	4,439	4,783	6,295	5,249	1,165	3,750
92	4,560	4,910	6,465	5,389	1,196	3,851
93	4,683	5,043	6,634	5,531	1,228	3,954
94	4,804	5,175	6,811	5,676	1,260	4,056
95	4,928	5,309	6,989	5,828	1,294	4,163
96	5,054	5,446	7,170	5,978	1,327	4,270
97	5,185	5,586	7,353	6,131	1,360	4,381
98	5,316	5,728	7,540	6,285	1,395	4,489
99+	5,450	5,869	7,728	6,443	1,429	4,601

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	6,056	6,524	8,586	7,159	1,588	5,115
65	2,438	2,625	3,458	2,879	641	1,945
66	2,438	2,625	3,458	2,879	641	1,945
67	2,438	2,625	3,458	2,879	641	1,945
68	2,463	2,654	3,495	2,913	646	2,016
69	2,520	2,714	3,573	2,978	662	2,100
70	2,584	2,785	3,666	3,056	679	2,179
71	2,663	2,871	3,778	3,150	699	2,253
72	2,744	2,959	3,893	3,248	721	2,330
73	2,835	3,056	4,023	3,353	745	2,413
74	2,936	3,164	4,165	3,470	771	2,491
75	3,040	3,274	4,306	3,593	797	2,571
76	3,145	3,389	4,460	3,716	826	2,656
77	3,256	3,509	4,615	3,849	854	2,744
78	3,365	3,625	4,773	3,978	884	2,835
79	3,470	3,738	4,924	4,108	911	2,926
80	3,580	3,854	5,078	4,233	941	3,025
81	3,691	3,979	5,239	4,368	969	3,120
82	3,803	4,094	5,389	4,496	998	3,213
83	3,919	4,225	5,561	4,638	1,028	3,313
84	4,034	4,343	5,721	4,770	1,059	3,409
85	4,181	4,504	5,929	4,944	1,097	3,530
86	4,301	4,631	6,103	5,088	1,128	3,634
87	4,421	4,765	6,271	5,226	1,160	3,738
88	4,546	4,896	6,449	5,376	1,194	3,841
89	4,673	5,033	6,628	5,524	1,227	3,948
90	4,803	5,174	6,810	5,675	1,260	4,054
91	4,933	5,315	6,995	5,830	1,295	4,166
92	5,066	5,455	7,185	5,988	1,329	4,280
93	5,201	5,603	7,375	6,146	1,365	4,391
94	5,338	5,751	7,570	6,311	1,401	4,508
95	5,479	5,900	7,766	6,473	1,438	4,626
96	5,618	6,053	7,966	6,641	1,474	4,745
97	5,760	6,209	8,171	6,813	1,511	4,868
98	5,906	6,365	8,375	6,984	1,550	4,990
99+	6,056	6,524	8,586	7,159	1,588	5,115

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 $1,676	$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

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

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 $2,870 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are $2,870. 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 $2,870 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 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.

****This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,870 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are $2,870. 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 $2,870 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	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $2,870 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	$0	$257 (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 $2,870 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 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