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: 04/2024 B

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 04/1/2024

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	4,207	4,533	5,967	4,975	1,380	3,554	4,674	5,037	6,631	5,528	1,533	3,948
65	1,694	1,824	2,401	2,000	556	1,352	1,883	2,027	2,668	2,223	618	1,503
66	1,694	1,824	2,401	2,000	556	1,352	1,883	2,027	2,668	2,223	618	1,503
67	1,694	1,824	2,401	2,000	556	1,352	1,883	2,027	2,668	2,223	618	1,503
68	1,712	1,844	2,428	2,024	562	1,402	1,903	2,050	2,697	2,249	624	1,557
69	1,750	1,886	2,484	2,068	575	1,459	1,946	2,096	2,759	2,299	639	1,622
70	1,796	1,935	2,546	2,125	589	1,514	1,995	2,150	2,831	2,359	655	1,683
71	1,853	1,994	2,624	2,188	607	1,566	2,057	2,216	2,916	2,433	675	1,742
72	1,908	2,056	2,707	2,257	626	1,619	2,120	2,283	3,006	2,507	696	1,800
73	1,972	2,122	2,796	2,330	647	1,675	2,190	2,359	3,106	2,587	719	1,861
74	2,040	2,198	2,894	2,411	669	1,730	2,267	2,441	3,217	2,680	744	1,923
75	2,112	2,274	2,994	2,495	693	1,788	2,347	2,529	3,327	2,773	769	1,985
76	2,186	2,354	3,099	2,584	717	1,845	2,428	2,617	3,444	2,870	797	2,050
77	2,262	2,436	3,207	2,673	743	1,907	2,513	2,707	3,563	2,971	825	2,119
78	2,339	2,521	3,318	2,766	768	1,969	2,601	2,799	3,685	3,071	854	2,189
79	2,413	2,599	3,421	2,852	791	2,035	2,681	2,887	3,801	3,169	879	2,260
80	2,488	2,680	3,526	2,939	817	2,102	2,764	2,977	3,922	3,268	908	2,337
81	2,566	2,765	3,641	3,033	842	2,168	2,850	3,071	4,043	3,370	936	2,409
82	2,643	2,847	3,747	3,124	867	2,231	2,936	3,164	4,161	3,472	963	2,480
83	2,723	2,935	3,864	3,220	894	2,301	3,027	3,261	4,292	3,580	992	2,556
84	2,803	3,020	3,976	3,316	920	2,368	3,116	3,354	4,416	3,682	1,022	2,632
85	2,907	3,129	4,120	3,435	953	2,453	3,231	3,479	4,578	3,817	1,059	2,725
86	2,988	3,218	4,238	3,533	980	2,525	3,321	3,575	4,711	3,926	1,089	2,805
87	3,072	3,311	4,358	3,633	1,008	2,596	3,414	3,679	4,843	4,037	1,120	2,886
88	3,159	3,403	4,482	3,736	1,037	2,671	3,509	3,781	4,979	4,151	1,152	2,965
89	3,249	3,498	4,605	3,838	1,066	2,742	3,608	3,887	5,117	4,265	1,184	3,047
90	3,337	3,596	4,731	3,945	1,094	2,818	3,709	3,993	5,258	4,383	1,217	3,131
91	3,428	3,693	4,861	4,052	1,124	2,895	3,807	4,103	5,401	4,502	1,250	3,217
92	3,522	3,792	4,993	4,160	1,154	2,973	3,912	4,214	5,547	4,622	1,283	3,303
93	3,615	3,894	5,124	4,272	1,185	3,053	4,017	4,326	5,693	4,746	1,318	3,390
94	3,710	3,996	5,259	4,385	1,217	3,132	4,121	4,441	5,845	4,873	1,352	3,481
95	3,806	4,100	5,398	4,499	1,249	3,215	4,230	4,555	5,997	4,998	1,388	3,572
96	3,905	4,206	5,537	4,615	1,281	3,297	4,338	4,673	6,153	5,128	1,423	3,664
97	4,003	4,313	5,678	4,734	1,313	3,383	4,449	4,793	6,309	5,259	1,459	3,758
98	4,105	4,422	5,821	4,853	1,346	3,467	4,561	4,913	6,468	5,393	1,496	3,853
99+	4,207	4,533	5,967	4,975	1,380	3,554	4,674	5,037	6,631	5,528	1,533	3,948

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 04/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	4,840	5,211	6,862	5,721	1,586	4,086
65	1,948	2,100	2,761	2,303	639	1,555
66	1,948	2,100	2,761	2,303	639	1,555
67	1,948	2,100	2,761	2,303	639	1,555
68	1,969	2,120	2,792	2,329	646	1,611
69	2,011	2,169	2,857	2,380	662	1,678
70	2,067	2,224	2,929	2,443	678	1,743
71	2,129	2,292	3,018	2,516	698	1,803
72	2,196	2,363	3,112	2,595	720	1,864
73	2,267	2,441	3,216	2,680	744	1,928
74	2,347	2,529	3,328	2,773	769	1,991
75	2,429	2,617	3,444	2,870	797	2,057
76	2,513	2,706	3,563	2,971	825	2,121
77	2,602	2,803	3,691	3,075	854	2,193
78	2,690	2,898	3,815	3,180	884	2,263
79	2,774	2,987	3,934	3,279	910	2,339
80	2,859	3,080	4,058	3,383	939	2,418
81	2,951	3,181	4,186	3,490	969	2,492
82	3,040	3,275	4,307	3,593	997	2,567
83	3,134	3,376	4,443	3,705	1,028	2,646
84	3,222	3,473	4,572	3,811	1,058	2,724
85	3,341	3,600	4,737	3,950	1,097	2,823
86	3,437	3,701	4,874	4,063	1,127	2,904
87	3,534	3,807	5,013	4,178	1,159	2,986
88	3,633	3,913	5,154	4,296	1,192	3,070
89	3,736	4,023	5,295	4,414	1,225	3,154
90	3,837	4,134	5,443	4,537	1,259	3,241
91	3,942	4,247	5,590	4,661	1,293	3,330
92	4,049	4,360	5,741	4,785	1,328	3,420
93	4,158	4,478	5,891	4,912	1,363	3,511
94	4,266	4,595	6,048	5,041	1,399	3,602
95	4,376	4,714	6,206	5,175	1,436	3,696
96	4,488	4,836	6,367	5,308	1,473	3,792
97	4,604	4,961	6,529	5,445	1,510	3,891
98	4,721	5,086	6,696	5,581	1,548	3,986
99+	4,840	5,211	6,862	5,721	1,586	4,086

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	5,378	5,793	7,625	6,357	1,763	4,542
65	2,165	2,331	3,070	2,556	712	1,727
66	2,165	2,331	3,070	2,556	712	1,727
67	2,165	2,331	3,070	2,556	712	1,727
68	2,187	2,357	3,104	2,586	717	1,790
69	2,238	2,410	3,172	2,644	735	1,865
70	2,294	2,473	3,256	2,714	754	1,935
71	2,364	2,550	3,354	2,797	776	2,000
72	2,436	2,627	3,457	2,884	800	2,069
73	2,517	2,714	3,572	2,977	827	2,142
74	2,607	2,809	3,699	3,081	856	2,212
75	2,700	2,907	3,824	3,190	885	2,283
76	2,793	3,009	3,960	3,300	917	2,359
77	2,892	3,116	4,098	3,418	948	2,436
78	2,988	3,219	4,238	3,532	981	2,517
79	3,081	3,319	4,372	3,647	1,011	2,599
80	3,179	3,422	4,509	3,758	1,045	2,686
81	3,278	3,533	4,652	3,878	1,076	2,771
82	3,377	3,635	4,785	3,993	1,108	2,853
83	3,480	3,752	4,938	4,118	1,141	2,942
84	3,582	3,856	5,080	4,236	1,175	3,027
85	3,713	3,999	5,265	4,390	1,218	3,135
86	3,820	4,113	5,419	4,518	1,252	3,227
87	3,926	4,231	5,569	4,641	1,288	3,319
88	4,037	4,348	5,726	4,774	1,325	3,411
89	4,149	4,469	5,885	4,905	1,362	3,505
90	4,265	4,594	6,047	5,039	1,399	3,600
91	4,380	4,720	6,212	5,177	1,437	3,700
92	4,499	4,844	6,380	5,317	1,475	3,801
93	4,619	4,975	6,549	5,458	1,515	3,899
94	4,740	5,107	6,722	5,604	1,555	4,003
95	4,865	5,239	6,896	5,748	1,596	4,108
96	4,988	5,375	7,074	5,897	1,636	4,214
97	5,115	5,513	7,256	6,050	1,677	4,322
98	5,245	5,652	7,437	6,202	1,721	4,431
99+	5,378	5,793	7,625	6,357	1,763	4,542

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 04/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	3,790	4,084	5,376	4,482	1,243	3,202
65	1,526	1,643	2,163	1,802	501	1,218
66	1,526	1,643	2,163	1,802	501	1,218
67	1,526	1,643	2,163	1,802	501	1,218
68	1,542	1,661	2,187	1,823	506	1,263
69	1,577	1,699	2,238	1,863	518	1,314
70	1,618	1,743	2,294	1,914	531	1,364
71	1,669	1,796	2,364	1,971	547	1,411
72	1,719	1,852	2,439	2,033	564	1,459
73	1,777	1,912	2,519	2,099	583	1,509
74	1,838	1,980	2,607	2,172	603	1,559
75	1,903	2,049	2,697	2,248	624	1,611
76	1,969	2,121	2,792	2,328	646	1,662
77	2,038	2,195	2,889	2,408	669	1,718
78	2,107	2,271	2,989	2,492	692	1,774
79	2,174	2,341	3,082	2,569	713	1,833
80	2,241	2,414	3,177	2,648	736	1,894
81	2,312	2,491	3,280	2,732	759	1,953
82	2,381	2,565	3,376	2,814	781	2,010
83	2,453	2,644	3,481	2,901	805	2,073
84	2,525	2,721	3,582	2,987	829	2,133
85	2,619	2,819	3,712	3,095	859	2,210
86	2,692	2,899	3,818	3,183	883	2,275
87	2,768	2,983	3,926	3,273	908	2,339
88	2,846	3,066	4,038	3,366	934	2,406
89	2,927	3,151	4,149	3,458	960	2,470
90	3,006	3,240	4,262	3,554	986	2,539
91	3,088	3,327	4,379	3,650	1,013	2,608
92	3,173	3,416	4,498	3,748	1,040	2,678
93	3,257	3,508	4,616	3,849	1,068	2,750
94	3,342	3,600	4,738	3,950	1,096	2,822
95	3,429	3,694	4,863	4,053	1,125	2,896
96	3,518	3,789	4,988	4,158	1,154	2,970
97	3,606	3,886	5,115	4,265	1,183	3,048
98	3,698	3,984	5,244	4,372	1,213	3,123
99+	3,790	4,084	5,376	4,482	1,243	3,202

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	4,211	4,538	5,974	4,980	1,381	3,557
65	1,696	1,826	2,404	2,003	557	1,354
66	1,696	1,826	2,404	2,003	557	1,354
67	1,696	1,826	2,404	2,003	557	1,354
68	1,714	1,847	2,430	2,026	562	1,403
69	1,753	1,888	2,486	2,071	576	1,461
70	1,797	1,937	2,550	2,125	590	1,516
71	1,853	1,996	2,627	2,192	608	1,569
72	1,910	2,057	2,708	2,259	627	1,622
73	1,973	2,125	2,798	2,331	648	1,677
74	2,042	2,199	2,898	2,414	670	1,732
75	2,114	2,278	2,997	2,498	693	1,788
76	2,187	2,358	3,103	2,586	718	1,847
77	2,264	2,439	3,210	2,677	743	1,909
78	2,343	2,522	3,320	2,767	769	1,972
79	2,415	2,601	3,424	2,855	792	2,036
80	2,490	2,682	3,533	2,944	818	2,105
81	2,568	2,767	3,642	3,036	843	2,170
82	2,645	2,850	3,749	3,128	868	2,234
83	2,727	2,938	3,867	3,225	894	2,303
84	2,807	3,022	3,978	3,317	921	2,371
85	2,911	3,134	4,124	3,439	954	2,455
86	2,992	3,221	4,244	3,537	981	2,527
87	3,076	3,314	4,363	3,637	1,009	2,600
88	3,161	3,406	4,486	3,740	1,038	2,671
89	3,250	3,502	4,610	3,842	1,067	2,745
90	3,341	3,597	4,737	3,949	1,096	2,821
91	3,430	3,696	4,866	4,056	1,126	2,898
92	3,524	3,796	4,997	4,164	1,156	2,976
93	3,619	3,897	5,129	4,276	1,187	3,054
94	3,713	4,001	5,266	4,390	1,218	3,136
95	3,811	4,104	5,403	4,503	1,250	3,218
96	3,908	4,210	5,543	4,620	1,282	3,301
97	4,008	4,318	5,684	4,738	1,314	3,386
98	4,109	4,426	5,827	4,859	1,348	3,471
99+	4,211	4,538	5,974	4,980	1,381	3,557

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

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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 04/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	4,360	4,695	6,182	5,154	1,429	3,681
65	1,755	1,892	2,487	2,075	576	1,401
66	1,755	1,892	2,487	2,075	576	1,401
67	1,755	1,892	2,487	2,075	576	1,401
68	1,774	1,910	2,515	2,098	582	1,451
69	1,812	1,954	2,574	2,144	596	1,512
70	1,862	2,004	2,639	2,201	611	1,570
71	1,918	2,065	2,719	2,267	629	1,624
72	1,978	2,129	2,804	2,338	649	1,679
73	2,042	2,199	2,897	2,414	670	1,737
74	2,114	2,278	2,998	2,498	693	1,794
75	2,188	2,358	3,103	2,586	718	1,853
76	2,264	2,438	3,210	2,677	743	1,911
77	2,344	2,525	3,325	2,770	769	1,976
78	2,423	2,611	3,437	2,865	796	2,039
79	2,499	2,691	3,544	2,954	820	2,107
80	2,576	2,775	3,656	3,048	846	2,178
81	2,659	2,866	3,771	3,144	873	2,245
82	2,739	2,950	3,880	3,237	898	2,313
83	2,823	3,041	4,003	3,338	926	2,384
84	2,903	3,129	4,119	3,433	953	2,454
85	3,010	3,243	4,268	3,559	988	2,543
86	3,096	3,334	4,391	3,660	1,015	2,616
87	3,184	3,430	4,516	3,764	1,044	2,690
88	3,273	3,525	4,643	3,870	1,074	2,766
89	3,366	3,624	4,770	3,977	1,104	2,841
90	3,457	3,724	4,904	4,087	1,134	2,920
91	3,551	3,826	5,036	4,199	1,165	3,000
92	3,648	3,928	5,172	4,311	1,196	3,081
93	3,746	4,034	5,307	4,425	1,228	3,163
94	3,843	4,140	5,449	4,541	1,260	3,245
95	3,942	4,247	5,591	4,662	1,294	3,330
96	4,043	4,357	5,736	4,782	1,327	3,416
97	4,148	4,469	5,882	4,905	1,360	3,505
98	4,253	4,582	6,032	5,028	1,395	3,591
99+	4,360	4,695	6,182	5,154	1,429	3,681

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	4,845	5,219	6,869	5,727	1,588	4,092
65	1,950	2,100	2,766	2,303	641	1,556
66	1,950	2,100	2,766	2,303	641	1,556
67	1,950	2,100	2,766	2,303	641	1,556
68	1,970	2,123	2,796	2,330	646	1,613
69	2,016	2,171	2,858	2,382	662	1,680
70	2,067	2,228	2,933	2,445	679	1,743
71	2,130	2,297	3,022	2,520	699	1,802
72	2,195	2,367	3,114	2,598	721	1,864
73	2,268	2,445	3,218	2,682	745	1,930
74	2,349	2,531	3,332	2,776	771	1,993
75	2,432	2,619	3,445	2,874	797	2,057
76	2,516	2,711	3,568	2,973	826	2,125
77	2,605	2,807	3,692	3,079	854	2,195
78	2,692	2,900	3,818	3,182	884	2,268
79	2,776	2,990	3,939	3,286	911	2,341
80	2,864	3,083	4,062	3,386	941	2,420
81	2,953	3,183	4,191	3,494	969	2,496
82	3,042	3,275	4,311	3,597	998	2,570
83	3,135	3,380	4,449	3,710	1,028	2,650
84	3,227	3,474	4,577	3,816	1,059	2,727
85	3,345	3,603	4,743	3,955	1,097	2,824
86	3,441	3,705	4,882	4,070	1,128	2,907
87	3,537	3,812	5,017	4,181	1,160	2,990
88	3,637	3,917	5,159	4,301	1,194	3,073
89	3,738	4,026	5,302	4,419	1,227	3,158
90	3,842	4,139	5,448	4,540	1,260	3,243
91	3,946	4,252	5,596	4,664	1,295	3,333
92	4,053	4,364	5,748	4,790	1,329	3,424
93	4,161	4,482	5,900	4,917	1,365	3,513
94	4,270	4,601	6,056	5,049	1,401	3,606
95	4,383	4,720	6,213	5,178	1,438	3,701
96	4,494	4,842	6,373	5,313	1,474	3,796
97	4,608	4,967	6,537	5,450	1,511	3,894
98	4,725	5,092	6,700	5,587	1,550	3,992
99+	4,845	5,219	6,869	5,727	1,588	4,092

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