Outline of coverage

Medicare Supplement Insurance

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

Colorado

Underwritten by

Aetna Health Insurance Company

AetnaSeniorProducts.com

AHCMS05034CO

Rates effective: 08/2024 B

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. 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.

In Colorado, it is a requirement that all plans offered by Aetna Health Insurance Company are available to under age 65 Medicare qualified individuals.

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: 800-802
Female rates

Rates effective 8/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,285	3,564	4,796	896	3,632	2,229
65	2,191	2,378	3,198	597	2,419	1,487
66	2,191	2,378	3,198	597	2,419	1,487
67	2,191	2,378	3,198	597	2,419	1,487
68	2,213	2,404	3,231	603	2,448	1,540
69	2,259	2,452	3,303	618	2,501	1,601
70	2,318	2,515	3,383	633	2,561	1,659
71	2,390	2,596	3,488	651	2,642	1,720
72	2,466	2,672	3,600	673	2,726	1,780
73	2,547	2,763	3,718	695	2,814	1,839
74	2,631	2,858	3,842	718	2,910	1,900
75	2,727	2,959	3,982	745	3,015	1,965
76	2,823	3,062	4,122	770	3,120	2,026
77	2,923	3,170	4,267	798	3,230	2,093
78	3,022	3,280	4,412	824	3,339	2,164
79	3,120	3,384	4,557	852	3,450	2,236
80	3,218	3,493	4,696	878	3,558	2,311
81	3,318	3,604	4,848	906	3,670	2,384
82	3,421	3,717	4,998	935	3,787	2,459
83	3,530	3,832	5,152	963	3,901	2,535
84	3,637	3,947	5,310	992	4,021	2,613
85	3,758	4,082	5,487	1,026	4,153	2,700
86	3,867	4,196	5,644	1,055	4,271	2,775
87	3,973	4,313	5,801	1,085	4,393	2,854
88	4,087	4,434	5,966	1,115	4,517	2,935
89	4,200	4,558	6,131	1,147	4,644	3,015
90	4,314	4,684	6,300	1,177	4,771	3,098
91	4,433	4,814	6,474	1,210	4,901	3,183
92	4,552	4,940	6,649	1,242	5,032	3,269
93	4,673	5,074	6,825	1,275	5,165	3,356
94	4,799	5,208	7,005	1,310	5,301	3,445
95	4,923	5,343	7,188	1,342	5,441	3,535
96	5,051	5,479	7,374	1,379	5,584	3,627
97	5,179	5,623	7,562	1,414	5,725	3,720
98	5,311	5,764	7,754	1,449	5,871	3,815
99+	5,444	5,908	7,945	1,486	6,017	3,909

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,652	3,964	5,329	996	4,035	2,477
65	2,434	2,643	3,553	664	2,692	1,652
66	2,434	2,643	3,553	664	2,692	1,652
67	2,434	2,643	3,553	664	2,692	1,652
68	2,459	2,669	3,590	672	2,719	1,712
69	2,509	2,727	3,669	686	2,779	1,780
70	2,575	2,793	3,760	703	2,844	1,844
71	2,654	2,884	3,877	724	2,937	1,911
72	2,738	2,972	3,998	748	3,027	1,979
73	2,828	3,069	4,130	772	3,126	2,043
74	2,923	3,173	4,269	798	3,230	2,112
75	3,028	3,287	4,425	827	3,349	2,181
76	3,137	3,404	4,580	857	3,466	2,252
77	3,248	3,523	4,739	886	3,588	2,326
78	3,356	3,642	4,902	915	3,711	2,405
79	3,467	3,762	5,062	946	3,833	2,486
80	3,575	3,882	5,218	976	3,956	2,568
81	3,689	4,004	5,383	1,006	4,079	2,650
82	3,802	4,130	5,553	1,037	4,204	2,732
83	3,920	4,256	5,725	1,070	4,335	2,817
84	4,039	4,384	5,900	1,103	4,467	2,903
85	4,174	4,532	6,094	1,140	4,614	2,999
86	4,295	4,664	6,272	1,173	4,748	3,084
87	4,418	4,793	6,448	1,206	4,883	3,172
88	4,539	4,927	6,629	1,240	5,022	3,261
89	4,666	5,064	6,815	1,274	5,157	3,352
90	4,798	5,204	7,001	1,309	5,300	3,444
91	4,926	5,347	7,194	1,344	5,443	3,537
92	5,059	5,491	7,388	1,380	5,592	3,634
93	5,192	5,636	7,583	1,417	5,740	3,730
94	5,329	5,787	7,783	1,455	5,891	3,828
95	5,470	5,938	7,988	1,493	6,046	3,927
96	5,610	6,091	8,194	1,532	6,204	4,028
97	5,754	6,244	8,403	1,570	6,362	4,134
98	5,901	6,404	8,614	1,610	6,523	4,238
99+	6,047	6,564	8,830	1,651	6,686	4,341

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: 800-802
Male rates

Rates effective 8/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,778	4,103	5,517	1,029	4,174	2,564
65	2,520	2,733	3,676	686	2,784	1,710
66	2,520	2,733	3,676	686	2,784	1,710
67	2,520	2,733	3,676	686	2,784	1,710
68	2,547	2,763	3,719	695	2,815	1,771
69	2,599	2,823	3,797	710	2,876	1,842
70	2,666	2,892	3,893	728	2,945	1,907
71	2,748	2,984	4,014	749	3,039	1,980
72	2,833	3,077	4,139	774	3,133	2,045
73	2,927	3,176	4,271	799	3,235	2,116
74	3,026	3,284	4,419	826	3,343	2,184
75	3,136	3,404	4,580	857	3,466	2,258
76	3,246	3,523	4,739	885	3,587	2,330
77	3,362	3,649	4,904	918	3,718	2,407
78	3,475	3,772	5,074	947	3,841	2,489
79	3,590	3,892	5,239	980	3,966	2,572
80	3,701	4,018	5,404	1,011	4,092	2,658
81	3,817	4,145	5,573	1,041	4,219	2,741
82	3,936	4,273	5,748	1,075	4,353	2,828
83	4,056	4,406	5,923	1,107	4,487	2,914
84	4,183	4,539	6,108	1,141	4,622	3,002
85	4,322	4,694	6,310	1,180	4,777	3,104
86	4,444	4,825	6,488	1,214	4,913	3,191
87	4,571	4,963	6,674	1,249	5,051	3,283
88	4,699	5,101	6,862	1,283	5,196	3,374
89	4,828	5,241	7,052	1,319	5,338	3,467
90	4,964	5,387	7,246	1,355	5,486	3,563
91	5,100	5,534	7,443	1,391	5,636	3,659
92	5,236	5,684	7,647	1,428	5,788	3,761
93	5,375	5,832	7,846	1,466	5,940	3,860
94	5,516	5,986	8,058	1,505	6,100	3,963
95	5,662	6,145	8,266	1,545	6,258	4,063
96	5,806	6,304	8,480	1,585	6,421	4,171
97	5,956	6,464	8,694	1,625	6,583	4,279
98	6,107	6,629	8,918	1,666	6,752	4,386
99+	6,260	6,794	9,137	1,709	6,916	4,494

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,200	4,558	6,128	1,145	4,642	2,848
65	2,801	3,040	4,086	763	3,092	1,898
66	2,801	3,040	4,086	763	3,092	1,898
67	2,801	3,040	4,086	763	3,092	1,898
68	2,828	3,069	4,132	773	3,128	1,970
69	2,888	3,136	4,218	790	3,195	2,045
70	2,964	3,214	4,326	808	3,272	2,120
71	3,054	3,317	4,458	833	3,378	2,198
72	3,148	3,418	4,599	861	3,482	2,274
73	3,252	3,531	4,749	887	3,596	2,352
74	3,362	3,650	4,911	918	3,718	2,428
75	3,482	3,782	5,090	953	3,853	2,509
76	3,608	3,917	5,267	984	3,986	2,589
77	3,734	4,051	5,451	1,020	4,129	2,674
78	3,859	4,190	5,638	1,053	4,268	2,765
79	3,986	4,327	5,818	1,089	4,407	2,859
80	4,111	4,465	6,005	1,121	4,547	2,954
81	4,242	4,604	6,194	1,157	4,690	3,046
82	4,373	4,748	6,386	1,193	4,835	3,143
83	4,506	4,894	6,583	1,229	4,984	3,240
84	4,645	5,042	6,787	1,268	5,136	3,338
85	4,801	5,215	7,009	1,311	5,306	3,449
86	4,939	5,362	7,213	1,348	5,460	3,547
87	5,078	5,513	7,415	1,387	5,613	3,645
88	5,219	5,666	7,626	1,426	5,775	3,749
89	5,368	5,824	7,838	1,464	5,934	3,853
90	5,514	5,983	8,052	1,504	6,094	3,961
91	5,665	6,147	8,272	1,546	6,260	4,068
92	5,817	6,313	8,498	1,587	6,432	4,178
93	5,971	6,479	8,719	1,628	6,603	4,289
94	6,130	6,653	8,950	1,674	6,774	4,401
95	6,291	6,829	9,185	1,716	6,953	4,517
96	6,455	7,006	9,423	1,763	7,133	4,635
97	6,620	7,183	9,662	1,805	7,316	4,753
98	6,785	7,365	9,909	1,851	7,499	4,874
99+	6,954	7,548	10,153	1,898	7,687	4,993

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 8/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,907	3,154	4,244	793	3,214	1,973
65	1,939	2,104	2,830	528	2,141	1,316
66	1,939	2,104	2,830	528	2,141	1,316
67	1,939	2,104	2,830	528	2,141	1,316
68	1,958	2,127	2,859	534	2,166	1,363
69	1,999	2,170	2,923	547	2,213	1,417
70	2,051	2,226	2,994	560	2,266	1,468
71	2,115	2,297	3,087	576	2,338	1,522
72	2,182	2,365	3,186	596	2,412	1,575
73	2,254	2,445	3,290	615	2,490	1,627
74	2,328	2,529	3,400	635	2,575	1,681
75	2,413	2,619	3,524	659	2,668	1,739
76	2,498	2,710	3,648	681	2,761	1,793
77	2,587	2,805	3,776	706	2,858	1,852
78	2,674	2,903	3,904	729	2,955	1,915
79	2,761	2,995	4,033	754	3,053	1,979
80	2,848	3,091	4,156	777	3,149	2,045
81	2,936	3,189	4,290	802	3,248	2,110
82	3,027	3,289	4,423	827	3,351	2,176
83	3,124	3,391	4,559	852	3,452	2,243
84	3,219	3,493	4,699	878	3,558	2,312
85	3,326	3,612	4,856	908	3,675	2,389
86	3,422	3,713	4,995	934	3,780	2,456
87	3,516	3,817	5,134	960	3,888	2,526
88	3,617	3,924	5,280	987	3,997	2,597
89	3,717	4,034	5,426	1,015	4,110	2,668
90	3,818	4,145	5,575	1,042	4,222	2,742
91	3,923	4,260	5,729	1,071	4,337	2,817
92	4,028	4,372	5,884	1,099	4,453	2,893
93	4,135	4,490	6,040	1,128	4,571	2,970
94	4,247	4,609	6,199	1,159	4,691	3,049
95	4,357	4,728	6,361	1,188	4,815	3,128
96	4,470	4,849	6,526	1,220	4,942	3,210
97	4,583	4,976	6,692	1,251	5,066	3,292
98	4,700	5,101	6,862	1,282	5,196	3,376
99+	4,818	5,228	7,031	1,315	5,325	3,459

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,232	3,508	4,716	881	3,571	2,192
65	2,154	2,339	3,144	588	2,382	1,462
66	2,154	2,339	3,144	588	2,382	1,462
67	2,154	2,339	3,144	588	2,382	1,462
68	2,176	2,362	3,177	595	2,406	1,515
69	2,220	2,413	3,247	607	2,459	1,575
70	2,279	2,472	3,327	622	2,517	1,632
71	2,349	2,552	3,431	641	2,599	1,691
72	2,423	2,630	3,538	662	2,679	1,751
73	2,503	2,716	3,655	683	2,766	1,808
74	2,587	2,808	3,778	706	2,858	1,869
75	2,680	2,909	3,916	732	2,964	1,930
76	2,776	3,012	4,053	758	3,067	1,993
77	2,874	3,118	4,194	784	3,175	2,058
78	2,970	3,223	4,338	810	3,284	2,128
79	3,068	3,329	4,480	837	3,392	2,200
80	3,164	3,435	4,618	864	3,501	2,273
81	3,265	3,543	4,764	890	3,610	2,345
82	3,365	3,655	4,914	918	3,720	2,418
83	3,469	3,766	5,066	947	3,836	2,493
84	3,574	3,880	5,221	976	3,953	2,569
85	3,694	4,011	5,393	1,009	4,083	2,654
86	3,801	4,127	5,550	1,038	4,202	2,729
87	3,910	4,242	5,706	1,067	4,321	2,807
88	4,017	4,360	5,866	1,097	4,444	2,886
89	4,129	4,481	6,031	1,127	4,564	2,966
90	4,246	4,605	6,196	1,158	4,690	3,048
91	4,359	4,732	6,366	1,189	4,817	3,130
92	4,477	4,859	6,538	1,221	4,949	3,216
93	4,595	4,988	6,711	1,254	5,080	3,301
94	4,716	5,121	6,888	1,288	5,213	3,388
95	4,841	5,255	7,069	1,321	5,350	3,475
96	4,965	5,390	7,251	1,356	5,490	3,565
97	5,092	5,526	7,436	1,389	5,630	3,658
98	5,222	5,667	7,623	1,425	5,773	3,750
99+	5,351	5,809	7,814	1,461	5,917	3,842

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 8/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,343	3,631	4,882	911	3,694	2,269
65	2,230	2,419	3,253	607	2,464	1,513
66	2,230	2,419	3,253	607	2,464	1,513
67	2,230	2,419	3,253	607	2,464	1,513
68	2,254	2,445	3,291	615	2,491	1,567
69	2,300	2,498	3,360	628	2,545	1,630
70	2,359	2,559	3,445	644	2,606	1,688
71	2,432	2,641	3,552	663	2,689	1,752
72	2,507	2,723	3,663	685	2,773	1,810
73	2,590	2,811	3,780	707	2,863	1,873
74	2,678	2,906	3,911	731	2,958	1,933
75	2,775	3,012	4,053	758	3,067	1,998
76	2,873	3,118	4,194	783	3,174	2,062
77	2,975	3,229	4,340	812	3,290	2,130
78	3,075	3,338	4,490	838	3,399	2,203
79	3,177	3,444	4,636	867	3,510	2,276
80	3,275	3,556	4,782	895	3,621	2,352
81	3,378	3,668	4,932	921	3,734	2,426
82	3,483	3,781	5,087	951	3,852	2,503
83	3,589	3,899	5,242	980	3,971	2,579
84	3,702	4,017	5,405	1,010	4,090	2,657
85	3,825	4,154	5,584	1,044	4,227	2,747
86	3,933	4,270	5,742	1,074	4,348	2,824
87	4,045	4,392	5,906	1,105	4,470	2,905
88	4,158	4,514	6,073	1,135	4,598	2,986
89	4,273	4,638	6,241	1,167	4,724	3,068
90	4,393	4,767	6,412	1,199	4,855	3,153
91	4,513	4,897	6,587	1,231	4,988	3,238
92	4,634	5,030	6,767	1,264	5,122	3,328
93	4,757	5,161	6,943	1,297	5,257	3,416
94	4,881	5,297	7,131	1,332	5,398	3,507
95	5,011	5,438	7,315	1,367	5,538	3,596
96	5,138	5,579	7,504	1,403	5,682	3,691
97	5,271	5,720	7,694	1,438	5,826	3,787
98	5,404	5,866	7,892	1,474	5,975	3,881
99+	5,540	6,012	8,086	1,512	6,120	3,977

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,717	4,034	5,423	1,013	4,108	2,520
65	2,479	2,690	3,616	675	2,736	1,680
66	2,479	2,690	3,616	675	2,736	1,680
67	2,479	2,690	3,616	675	2,736	1,680
68	2,503	2,716	3,657	684	2,768	1,743
69	2,556	2,775	3,733	699	2,827	1,810
70	2,623	2,844	3,828	715	2,896	1,876
71	2,703	2,935	3,945	737	2,989	1,945
72	2,786	3,025	4,070	762	3,081	2,012
73	2,878	3,125	4,203	785	3,182	2,081
74	2,975	3,230	4,346	812	3,290	2,149
75	3,081	3,347	4,504	843	3,410	2,220
76	3,193	3,466	4,661	871	3,527	2,291
77	3,304	3,585	4,824	903	3,654	2,366
78	3,415	3,708	4,989	932	3,777	2,447
79	3,527	3,829	5,149	964	3,900	2,530
80	3,638	3,951	5,314	992	4,024	2,614
81	3,754	4,074	5,481	1,024	4,150	2,696
82	3,870	4,202	5,651	1,056	4,279	2,781
83	3,988	4,331	5,826	1,088	4,411	2,867
84	4,111	4,462	6,006	1,122	4,545	2,954
85	4,249	4,615	6,203	1,160	4,696	3,052
86	4,371	4,745	6,383	1,193	4,832	3,139
87	4,494	4,879	6,562	1,227	4,967	3,226
88	4,619	5,014	6,749	1,262	5,111	3,318
89	4,750	5,154	6,936	1,296	5,251	3,410
90	4,880	5,295	7,126	1,331	5,393	3,505
91	5,013	5,440	7,320	1,368	5,540	3,600
92	5,148	5,587	7,520	1,404	5,692	3,697
93	5,284	5,734	7,716	1,441	5,843	3,796
94	5,425	5,888	7,920	1,481	5,995	3,895
95	5,567	6,043	8,128	1,519	6,153	3,997
96	5,712	6,200	8,339	1,560	6,312	4,102
97	5,858	6,357	8,550	1,597	6,474	4,206
98	6,004	6,518	8,769	1,638	6,636	4,313
99+	6,154	6,680	8,985	1,680	6,803	4,419

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

IIn 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 be covered by an Aetna Company Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (b) someone with whom you are in a civil union partnership; and (c) someone with whom you have continuously resided for the past 12 months. The household discount will only be applicable if a policy for each applicant is issued. The discounted rate will be 7 percent lower than the individual rates and will apply as long as both policies remain in force.

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Aetna Health 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 all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

THE FOLLOWING CHARTS DESCRIBE PLANS A, B, F, HIGH DEDUCTIBLE F, G, and N OFFERED BY AETNA HEALTH INSURANCE COMPANY.

PLAN A

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

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

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

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

PLAN A

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

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

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

PARTS A & B

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

PLAN B

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

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

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

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

PLAN B

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

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

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

PARTS A & B

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

PLAN F

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

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

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

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

PLAN F

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

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

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

PARTS A & B

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

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE PLAN F

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

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

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

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

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

HIGH DEDUCTIBLE PLAN F

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

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

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

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

HIGH DEDUCTIBLE PLAN F

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN G

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

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

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

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

PLAN G

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

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

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

PARTS A & B

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

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

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

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

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

PLAN N

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

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

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

PLAN N

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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