Outline of coverage

Medicare Supplement Insurance

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

Louisiana

Underwritten by

Aetna Health Insurance Company

AetnaSeniorProducts.com

AHCMS04871LA

Rates effective: 04/2024 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. 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.

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 2024[2]					**$7,060[2]**	**$3,530[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,800** 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: 700-701, 703-704, 707-708

Female rates

Rates effective 4/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	7,682	9,053	10,494	9,227	2,537	6,565
65	1,819	2,143	2,483	2,183	600	1,465
66	1,819	2,143	2,483	2,183	600	1,465
67	1,819	2,143	2,483	2,183	600	1,465
68	1,838	2,167	2,509	2,208	607	1,518
69	1,878	2,216	2,568	2,257	620	1,580
70	1,928	2,274	2,636	2,318	637	1,640
71	1,987	2,342	2,714	2,388	656	1,698
72	2,051	2,417	2,798	2,460	677	1,757
73	2,117	2,494	2,891	2,542	698	1,814
74	2,190	2,584	2,992	2,629	724	1,877
75	2,266	2,674	3,097	2,722	749	1,938
76	2,346	2,764	3,205	2,819	775	1,999
77	2,428	2,861	3,319	2,917	802	2,068
78	2,510	2,959	3,430	3,016	829	2,136
79	2,588	3,054	3,539	3,110	856	2,204
80	2,671	3,148	3,649	3,210	882	2,278
81	2,754	3,247	3,764	3,310	910	2,347
82	2,837	3,343	3,876	3,409	937	2,419
83	2,923	3,448	3,994	3,514	966	2,494
84	3,010	3,547	4,112	3,614	995	2,567
85	3,119	3,677	4,262	3,746	1,031	2,659
86	3,209	3,782	4,382	3,854	1,060	2,736
87	3,299	3,889	4,510	3,962	1,090	2,813
88	3,391	4,000	4,633	4,075	1,121	2,892
89	3,487	4,110	4,763	4,188	1,152	2,972
90	3,582	4,223	4,895	4,303	1,183	3,054
91	3,679	4,336	5,027	4,418	1,216	3,137
92	3,779	4,452	5,161	4,541	1,248	3,221
93	3,880	4,573	5,299	4,661	1,282	3,308
94	3,982	4,693	5,441	4,783	1,315	3,395
95	4,085	4,814	5,581	4,910	1,350	3,484
96	4,192	4,940	5,728	5,035	1,385	3,572
97	4,297	5,066	5,870	5,165	1,420	3,665
98	4,408	5,195	6,019	5,296	1,456	3,757
99+	4,517	5,326	6,172	5,428	1,493	3,851

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	8,537	10,057	11,659	10,252	2,819	7,292
65	2,021	2,381	2,759	2,428	667	1,628
66	2,021	2,381	2,759	2,428	667	1,628
67	2,021	2,381	2,759	2,428	667	1,628
68	2,041	2,407	2,788	2,454	674	1,686
69	2,088	2,460	2,854	2,508	689	1,756
70	2,143	2,527	2,927	2,574	708	1,824
71	2,208	2,603	3,016	2,652	730	1,886
72	2,278	2,684	3,112	2,735	752	1,952
73	2,352	2,770	3,210	2,824	776	2,017
74	2,435	2,870	3,326	2,922	804	2,086
75	2,519	2,970	3,440	3,025	832	2,153
76	2,606	3,072	3,560	3,130	862	2,222
77	2,696	3,181	3,688	3,240	890	2,297
78	2,790	3,290	3,810	3,352	922	2,374
79	2,876	3,392	3,931	3,457	950	2,450
80	2,969	3,498	4,056	3,564	980	2,531
81	3,061	3,608	4,183	3,678	1,010	2,610
82	3,152	3,715	4,307	3,788	1,042	2,688
83	3,247	3,829	4,441	3,906	1,073	2,771
84	3,346	3,941	4,568	4,018	1,105	2,851
85	3,466	4,085	4,735	4,165	1,145	2,956
86	3,564	4,202	4,868	4,280	1,177	3,040
87	3,665	4,320	5,010	4,405	1,211	3,126
88	3,768	4,444	5,150	4,526	1,246	3,212
89	3,875	4,565	5,293	4,652	1,280	3,302
90	3,982	4,691	5,438	4,782	1,315	3,394
91	4,088	4,819	5,585	4,913	1,351	3,486
92	4,198	4,949	5,735	5,044	1,387	3,580
93	4,312	5,081	5,888	5,178	1,424	3,674
94	4,424	5,214	6,044	5,316	1,462	3,772
95	4,538	5,351	6,200	5,454	1,500	3,871
96	4,657	5,489	6,362	5,596	1,538	3,972
97	4,776	5,629	6,523	5,738	1,577	4,073
98	4,897	5,771	6,689	5,882	1,618	4,176
99+	5,017	5,916	6,856	6,031	1,658	4,279

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

To calculate a 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: 700-701, 703-704, 707-708

Male rates

Rates effective 4/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	8,834	10,409	12,067	10,609	2,917	7,549
65	2,090	2,464	2,855	2,510	690	1,686
66	2,090	2,464	2,855	2,510	690	1,686
67	2,090	2,464	2,855	2,510	690	1,686
68	2,116	2,490	2,886	2,539	698	1,746
69	2,161	2,548	2,953	2,597	714	1,818
70	2,218	2,616	3,029	2,665	733	1,886
71	2,284	2,693	3,121	2,743	755	1,952
72	2,356	2,779	3,220	2,830	779	2,021
73	2,435	2,868	3,323	2,922	803	2,087
74	2,520	2,970	3,443	3,025	832	2,159
75	2,606	3,073	3,560	3,130	862	2,227
76	2,698	3,180	3,688	3,240	892	2,300
77	2,791	3,292	3,815	3,355	922	2,376
78	2,887	3,404	3,946	3,469	954	2,456
79	2,975	3,512	4,068	3,580	984	2,536
80	3,072	3,623	4,196	3,691	1,014	2,620
81	3,168	3,734	4,331	3,808	1,046	2,701
82	3,260	3,845	4,458	3,918	1,078	2,780
83	3,364	3,965	4,594	4,040	1,111	2,868
84	3,461	4,078	4,729	4,158	1,144	2,950
85	3,587	4,226	4,901	4,308	1,186	3,058
86	3,691	4,349	5,041	4,433	1,218	3,145
87	3,792	4,470	5,185	4,558	1,253	3,236
88	3,899	4,598	5,330	4,686	1,289	3,326
89	4,009	4,723	5,480	4,814	1,325	3,416
90	4,118	4,854	5,629	4,949	1,361	3,512
91	4,231	4,986	5,780	5,082	1,398	3,607
92	4,345	5,120	5,935	5,220	1,435	3,706
93	4,463	5,260	6,096	5,360	1,474	3,803
94	4,578	5,398	6,256	5,501	1,512	3,906
95	4,698	5,537	6,419	5,647	1,553	4,006
96	4,820	5,683	6,587	5,794	1,592	4,110
97	4,942	5,826	6,752	5,938	1,632	4,214
98	5,068	5,972	6,924	6,089	1,674	4,320
99+	5,196	6,124	7,099	6,239	1,717	4,428

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	9,815	11,567	13,408	11,792	3,241	8,387
65	2,324	2,738	3,173	2,789	767	1,873
66	2,324	2,738	3,173	2,789	767	1,873
67	2,324	2,738	3,173	2,789	767	1,873
68	2,347	2,768	3,205	2,822	775	1,940
69	2,401	2,831	3,281	2,885	792	2,018
70	2,464	2,905	3,366	2,960	815	2,099
71	2,539	2,990	3,467	3,052	839	2,170
72	2,620	3,085	3,578	3,145	865	2,244
73	2,704	3,186	3,692	3,246	893	2,318
74	2,797	3,299	3,826	3,360	925	2,398
75	2,896	3,414	3,956	3,478	956	2,474
76	2,998	3,532	4,096	3,600	991	2,555
77	3,100	3,658	4,241	3,727	1,024	2,641
78	3,209	3,782	4,382	3,854	1,060	2,730
79	3,308	3,900	4,519	3,976	1,093	2,818
80	3,412	4,024	4,664	4,100	1,128	2,910
81	3,521	4,151	4,810	4,230	1,162	3,001
82	3,625	4,274	4,952	4,355	1,198	3,091
83	3,734	4,405	5,105	4,490	1,234	3,186
84	3,846	4,534	5,252	4,620	1,271	3,277
85	3,986	4,698	5,446	4,787	1,316	3,397
86	4,099	4,831	5,600	4,924	1,354	3,494
87	4,214	4,968	5,760	5,063	1,392	3,595
88	4,333	5,108	5,922	5,206	1,433	3,695
89	4,456	5,250	6,086	5,352	1,472	3,798
90	4,578	5,394	6,254	5,500	1,512	3,901
91	4,700	5,539	6,422	5,650	1,554	4,008
92	4,829	5,688	6,596	5,800	1,595	4,115
93	4,957	5,843	6,773	5,954	1,638	4,225
94	5,087	5,996	6,952	6,114	1,681	4,339
95	5,218	6,152	7,130	6,274	1,726	4,451
96	5,356	6,313	7,318	6,434	1,769	4,566
97	5,494	6,473	7,504	6,599	1,813	4,682
98	5,632	6,636	7,693	6,764	1,860	4,801
99+	5,771	6,802	7,885	6,935	1,907	4,921

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

To calculate a 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 4/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	6,402	7,544	8,745	7,689	2,114	5,471
65	1,516	1,786	2,069	1,819	500	1,221
66	1,516	1,786	2,069	1,819	500	1,221
67	1,516	1,786	2,069	1,819	500	1,221
68	1,532	1,806	2,091	1,840	506	1,265
69	1,565	1,847	2,140	1,881	517	1,317
70	1,607	1,895	2,197	1,932	531	1,367
71	1,656	1,952	2,262	1,990	547	1,415
72	1,709	2,014	2,332	2,050	564	1,464
73	1,764	2,078	2,409	2,118	582	1,512
74	1,825	2,153	2,493	2,191	603	1,564
75	1,888	2,228	2,581	2,268	624	1,615
76	1,955	2,303	2,671	2,349	646	1,666
77	2,023	2,384	2,766	2,431	668	1,723
78	2,092	2,466	2,858	2,513	691	1,780
79	2,157	2,545	2,949	2,592	713	1,837
80	2,226	2,623	3,041	2,675	735	1,898
81	2,295	2,706	3,137	2,758	758	1,956
82	2,364	2,786	3,230	2,841	781	2,016
83	2,436	2,873	3,328	2,928	805	2,078
84	2,508	2,956	3,427	3,012	829	2,139
85	2,599	3,064	3,552	3,122	859	2,216
86	2,674	3,152	3,652	3,212	883	2,280
87	2,749	3,241	3,758	3,302	908	2,344
88	2,826	3,333	3,861	3,396	934	2,410
89	2,906	3,425	3,969	3,490	960	2,477
90	2,985	3,519	4,079	3,586	986	2,545
91	3,066	3,613	4,189	3,682	1,013	2,614
92	3,149	3,710	4,301	3,784	1,040	2,684
93	3,233	3,811	4,416	3,884	1,068	2,757
94	3,318	3,911	4,534	3,986	1,096	2,829
95	3,404	4,012	4,651	4,092	1,125	2,903
96	3,493	4,117	4,773	4,196	1,154	2,977
97	3,581	4,222	4,892	4,304	1,183	3,054
98	3,673	4,329	5,016	4,413	1,213	3,131
99+	3,764	4,438	5,143	4,523	1,244	3,209

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	7,114	8,381	9,716	8,543	2,349	6,077
65	1,684	1,984	2,299	2,023	556	1,357
66	1,684	1,984	2,299	2,023	556	1,357
67	1,684	1,984	2,299	2,023	556	1,357
68	1,701	2,006	2,323	2,045	562	1,405
69	1,740	2,050	2,378	2,090	574	1,463
70	1,786	2,106	2,439	2,145	590	1,520
71	1,840	2,169	2,513	2,210	608	1,572
72	1,898	2,237	2,593	2,279	627	1,627
73	1,960	2,308	2,675	2,353	647	1,681
74	2,029	2,392	2,772	2,435	670	1,738
75	2,099	2,475	2,867	2,521	693	1,794
76	2,172	2,560	2,967	2,608	718	1,852
77	2,247	2,651	3,073	2,700	742	1,914
78	2,325	2,742	3,175	2,793	768	1,978
79	2,397	2,827	3,276	2,881	792	2,042
80	2,474	2,915	3,380	2,970	817	2,109
81	2,551	3,007	3,486	3,065	842	2,175
82	2,627	3,096	3,589	3,157	868	2,240
83	2,706	3,191	3,701	3,255	894	2,309
84	2,788	3,284	3,807	3,348	921	2,376
85	2,888	3,404	3,946	3,471	954	2,463
86	2,970	3,502	4,057	3,567	981	2,533
87	3,054	3,600	4,175	3,671	1,009	2,605
88	3,140	3,703	4,292	3,772	1,038	2,677
89	3,229	3,804	4,411	3,877	1,067	2,752
90	3,318	3,909	4,532	3,985	1,096	2,828
91	3,407	4,016	4,654	4,094	1,126	2,905
92	3,498	4,124	4,779	4,203	1,156	2,983
93	3,593	4,234	4,907	4,315	1,187	3,062
94	3,687	4,345	5,037	4,430	1,218	3,143
95	3,782	4,459	5,167	4,545	1,250	3,226
96	3,881	4,574	5,302	4,663	1,282	3,310
97	3,980	4,691	5,436	4,782	1,314	3,394
98	4,081	4,809	5,574	4,902	1,348	3,480
99+	4,181	4,930	5,713	5,026	1,382	3,566

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

To calculate a household discount:

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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 4/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	7,362	8,674	10,056	8,841	2,431	6,291
65	1,742	2,053	2,379	2,092	575	1,405
66	1,742	2,053	2,379	2,092	575	1,405
67	1,742	2,053	2,379	2,092	575	1,405
68	1,763	2,075	2,405	2,116	582	1,455
69	1,801	2,123	2,461	2,164	595	1,515
70	1,848	2,180	2,524	2,221	611	1,572
71	1,903	2,244	2,601	2,286	629	1,627
72	1,963	2,316	2,683	2,358	649	1,684
73	2,029	2,390	2,769	2,435	669	1,739
74	2,100	2,475	2,869	2,521	693	1,799
75	2,172	2,561	2,967	2,608	718	1,856
76	2,248	2,650	3,073	2,700	743	1,917
77	2,326	2,743	3,179	2,796	768	1,980
78	2,406	2,837	3,288	2,891	795	2,047
79	2,479	2,927	3,390	2,983	820	2,113
80	2,560	3,019	3,497	3,076	845	2,183
81	2,640	3,112	3,609	3,173	872	2,251
82	2,717	3,204	3,715	3,265	898	2,317
83	2,803	3,304	3,828	3,367	926	2,390
84	2,884	3,398	3,941	3,465	953	2,458
85	2,989	3,522	4,084	3,590	988	2,548
86	3,076	3,624	4,201	3,694	1,015	2,621
87	3,160	3,725	4,321	3,798	1,044	2,697
88	3,249	3,832	4,442	3,905	1,074	2,772
89	3,341	3,936	4,567	4,012	1,104	2,847
90	3,432	4,045	4,691	4,124	1,134	2,927
91	3,526	4,155	4,817	4,235	1,165	3,006
92	3,621	4,267	4,946	4,350	1,196	3,088
93	3,719	4,383	5,080	4,467	1,228	3,169
94	3,815	4,498	5,213	4,584	1,260	3,255
95	3,915	4,614	5,349	4,706	1,294	3,338
96	4,017	4,736	5,489	4,828	1,327	3,425
97	4,118	4,855	5,627	4,948	1,360	3,512
98	4,223	4,977	5,770	5,074	1,395	3,600
99+	4,330	5,103	5,916	5,199	1,431	3,690

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	8,179	9,639	11,173	9,827	2,701	6,989
65	1,937	2,282	2,644	2,324	639	1,561
66	1,937	2,282	2,644	2,324	639	1,561
67	1,937	2,282	2,644	2,324	639	1,561
68	1,956	2,307	2,671	2,352	646	1,617
69	2,001	2,359	2,734	2,404	660	1,682
70	2,053	2,421	2,805	2,467	679	1,749
71	2,116	2,492	2,889	2,543	699	1,808
72	2,183	2,571	2,982	2,621	721	1,870
73	2,253	2,655	3,077	2,705	744	1,932
74	2,331	2,749	3,188	2,800	771	1,998
75	2,413	2,845	3,297	2,898	797	2,062
76	2,498	2,943	3,413	3,000	826	2,129
77	2,583	3,048	3,534	3,106	853	2,201
78	2,674	3,152	3,652	3,212	883	2,275
79	2,757	3,250	3,766	3,313	911	2,348
80	2,843	3,353	3,887	3,417	940	2,425
81	2,934	3,459	4,008	3,525	968	2,501
82	3,021	3,562	4,127	3,629	998	2,576
83	3,112	3,671	4,254	3,742	1,028	2,655
84	3,205	3,778	4,377	3,850	1,059	2,731
85	3,322	3,915	4,538	3,989	1,097	2,831
86	3,416	4,026	4,667	4,103	1,128	2,912
87	3,512	4,140	4,800	4,219	1,160	2,996
88	3,611	4,257	4,935	4,338	1,194	3,079
89	3,713	4,375	5,072	4,460	1,227	3,165
90	3,815	4,495	5,212	4,583	1,260	3,251
91	3,917	4,616	5,352	4,708	1,295	3,340
92	4,024	4,740	5,497	4,833	1,329	3,429
93	4,131	4,869	5,644	4,962	1,365	3,521
94	4,239	4,997	5,793	5,095	1,401	3,616
95	4,348	5,127	5,942	5,228	1,438	3,709
96	4,463	5,261	6,098	5,362	1,474	3,805
97	4,578	5,394	6,253	5,499	1,511	3,902
98	4,693	5,530	6,411	5,637	1,550	4,001
99+	4,809	5,668	6,571	5,779	1,589	4,101

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

To calculate a 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 a policy for each 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 $1,632	$0	$1,632 (Part A Deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 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 $240 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 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 $240 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 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 $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$240 (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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $2,800 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are $2,800. 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 $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 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 $2,800 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are $2,800. 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 $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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