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: 03/2022 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 2022[2]					**$6,620[2]**	**$3,310[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,490 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 03/1/2022

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	6,128	7,222	8,371	7,361	2,537	5,237
65	1,451	1,710	1,980	1,741	600	1,169
66	1,451	1,710	1,980	1,741	600	1,169
67	1,451	1,710	1,980	1,741	600	1,169
68	1,466	1,728	2,002	1,762	607	1,211
69	1,499	1,768	2,048	1,801	620	1,260
70	1,538	1,814	2,102	1,849	637	1,309
71	1,585	1,868	2,166	1,904	656	1,354
72	1,636	1,927	2,233	1,963	677	1,402
73	1,688	1,990	2,306	2,028	698	1,447
74	1,747	2,060	2,387	2,098	724	1,498
75	1,807	2,132	2,471	2,171	749	1,546
76	1,872	2,206	2,557	2,249	775	1,595
77	1,937	2,282	2,647	2,327	802	1,649
78	2,003	2,360	2,736	2,406	829	1,704
79	2,065	2,436	2,822	2,482	856	1,758
80	2,131	2,512	2,911	2,561	882	1,817
81	2,197	2,591	3,004	2,640	910	1,873
82	2,263	2,668	3,092	2,719	937	1,930
83	2,332	2,750	3,186	2,803	966	1,990
84	2,401	2,830	3,281	2,884	995	2,047
85	2,488	2,933	3,401	2,989	1,031	2,122
86	2,560	3,018	3,497	3,074	1,060	2,183
87	2,632	3,102	3,598	3,161	1,090	2,244
88	2,705	3,191	3,696	3,251	1,121	2,308
89	2,782	3,278	3,799	3,341	1,152	2,371
90	2,858	3,368	3,905	3,433	1,183	2,436
91	2,935	3,460	4,010	3,526	1,216	2,502
92	3,014	3,552	4,117	3,622	1,248	2,569
93	3,095	3,648	4,228	3,718	1,282	2,639
94	3,176	3,744	4,340	3,816	1,315	2,708
95	3,259	3,841	4,452	3,917	1,350	2,779
96	3,343	3,941	4,568	4,018	1,385	2,850
97	3,428	4,042	4,684	4,121	1,420	2,924
98	3,516	4,144	4,802	4,224	1,456	2,998
99+	3,604	4,248	4,924	4,330	1,493	3,072

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	6,810	8,023	9,301	8,179	2,819	5,818
65	1,612	1,900	2,201	1,937	667	1,300
66	1,612	1,900	2,201	1,937	667	1,300
67	1,612	1,900	2,201	1,937	667	1,300
68	1,628	1,920	2,224	1,957	674	1,345
69	1,666	1,963	2,276	2,000	689	1,400
70	1,710	2,016	2,335	2,053	708	1,456
71	1,762	2,076	2,406	2,116	730	1,505
72	1,817	2,141	2,483	2,182	752	1,558
73	1,876	2,209	2,561	2,252	776	1,609
74	1,942	2,290	2,653	2,330	804	1,663
75	2,009	2,369	2,744	2,413	832	1,717
76	2,080	2,450	2,840	2,497	862	1,772
77	2,152	2,538	2,941	2,585	890	1,832
78	2,226	2,624	3,040	2,674	922	1,894
79	2,294	2,706	3,137	2,758	950	1,955
80	2,368	2,791	3,235	2,844	980	2,020
81	2,442	2,879	3,337	2,934	1,010	2,082
82	2,514	2,964	3,436	3,022	1,042	2,144
83	2,591	3,055	3,542	3,115	1,073	2,210
84	2,669	3,144	3,644	3,205	1,105	2,274
85	2,765	3,259	3,778	3,323	1,145	2,358
86	2,844	3,353	3,884	3,415	1,177	2,425
87	2,924	3,446	3,996	3,514	1,211	2,494
88	3,006	3,545	4,109	3,611	1,246	2,563
89	3,091	3,642	4,223	3,712	1,280	2,634
90	3,176	3,742	4,339	3,815	1,315	2,707
91	3,262	3,845	4,456	3,919	1,351	2,780
92	3,349	3,948	4,576	4,024	1,387	2,856
93	3,439	4,054	4,698	4,130	1,424	2,932
94	3,529	4,159	4,822	4,241	1,462	3,008
95	3,620	4,268	4,946	4,351	1,500	3,088
96	3,715	4,379	5,075	4,464	1,538	3,168
97	3,810	4,490	5,204	4,578	1,577	3,248
98	3,907	4,604	5,336	4,693	1,618	3,331
99+	4,003	4,720	5,470	4,811	1,658	3,414

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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 Period, use Preferred rates.

Aetna Health Insurance Company

Annual Premiums

For Use in ZIP Codes: 700-701, 703-704, 707-708

Male Rates

Rates Effective 03/1/2022

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	7,048	8,304	9,626	8,464	2,917	6,022
65	1,668	1,966	2,278	2,003	690	1,345
66	1,668	1,966	2,278	2,003	690	1,345
67	1,668	1,966	2,278	2,003	690	1,345
68	1,687	1,986	2,302	2,026	698	1,393
69	1,724	2,033	2,356	2,072	714	1,450
70	1,769	2,087	2,417	2,126	733	1,505
71	1,822	2,148	2,490	2,189	755	1,558
72	1,879	2,218	2,568	2,257	779	1,612
73	1,942	2,287	2,651	2,330	803	1,664
74	2,010	2,369	2,747	2,413	832	1,722
75	2,080	2,452	2,840	2,497	862	1,777
76	2,153	2,537	2,941	2,585	892	1,835
77	2,227	2,626	3,043	2,676	922	1,896
78	2,303	2,716	3,148	2,767	954	1,960
79	2,374	2,802	3,246	2,856	984	2,022
80	2,450	2,890	3,348	2,945	1,014	2,089
81	2,527	2,980	3,455	3,037	1,046	2,154
82	2,602	3,067	3,556	3,126	1,078	2,219
83	2,683	3,163	3,665	3,223	1,111	2,287
84	2,761	3,253	3,773	3,317	1,144	2,353
85	2,861	3,372	3,910	3,437	1,186	2,440
86	2,945	3,469	4,021	3,536	1,218	2,509
87	3,025	3,566	4,136	3,636	1,253	2,581
88	3,110	3,668	4,253	3,739	1,289	2,653
89	3,198	3,768	4,372	3,841	1,325	2,726
90	3,286	3,872	4,490	3,948	1,361	2,802
91	3,376	3,978	4,612	4,055	1,398	2,878
92	3,467	4,085	4,735	4,165	1,435	2,956
93	3,560	4,195	4,862	4,276	1,474	3,034
94	3,652	4,306	4,991	4,388	1,512	3,115
95	3,748	4,417	5,120	4,505	1,553	3,196
96	3,846	4,534	5,255	4,621	1,592	3,278
97	3,942	4,648	5,387	4,738	1,632	3,362
98	4,043	4,765	5,524	4,858	1,674	3,446
99+	4,145	4,885	5,663	4,978	1,717	3,533

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	7,830	9,228	10,697	9,407	3,241	6,690
65	1,854	2,184	2,531	2,225	767	1,494
66	1,854	2,184	2,531	2,225	767	1,494
67	1,854	2,184	2,531	2,225	767	1,494
68	1,873	2,208	2,557	2,251	775	1,548
69	1,915	2,258	2,617	2,300	792	1,610
70	1,966	2,317	2,686	2,362	815	1,674
71	2,026	2,386	2,766	2,434	839	1,730
72	2,089	2,461	2,855	2,509	865	1,790
73	2,156	2,542	2,946	2,590	893	1,849
74	2,232	2,632	3,052	2,681	925	1,913
75	2,310	2,724	3,156	2,774	956	1,974
76	2,392	2,818	3,268	2,873	991	2,038
77	2,473	2,917	3,383	2,974	1,024	2,107
78	2,560	3,018	3,497	3,074	1,060	2,178
79	2,639	3,112	3,606	3,172	1,093	2,248
80	2,722	3,210	3,721	3,271	1,128	2,322
81	2,808	3,312	3,836	3,374	1,162	2,394
82	2,892	3,409	3,952	3,474	1,198	2,466
83	2,980	3,514	4,073	3,582	1,234	2,542
84	3,068	3,617	4,190	3,686	1,271	2,615
85	3,180	3,748	4,344	3,820	1,316	2,711
86	3,270	3,854	4,468	3,928	1,354	2,788
87	3,362	3,964	4,595	4,039	1,392	2,868
88	3,457	4,075	4,724	4,153	1,433	2,947
89	3,554	4,188	4,855	4,270	1,472	3,030
90	3,652	4,303	4,990	4,387	1,512	3,113
91	3,750	4,420	5,124	4,507	1,554	3,197
92	3,852	4,538	5,262	4,627	1,595	3,283
93	3,954	4,661	5,404	4,751	1,638	3,371
94	4,058	4,783	5,545	4,877	1,681	3,461
95	4,163	4,908	5,688	5,005	1,726	3,551
96	4,273	5,036	5,838	5,134	1,769	3,643
97	4,382	5,164	5,986	5,264	1,813	3,736
98	4,493	5,294	6,138	5,396	1,860	3,830
99+	4,604	5,426	6,290	5,532	1,907	3,926

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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 Period, use Preferred rates.

Aetna Health Insurance Company

Annual Premiums
For Use in: Rest of State
Female Rates

Rates Effective 03/1/2022

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	5,107	6,018	6,976	6,134	2,114	4,364
65	1,209	1,425	1,650	1,451	500	974
66	1,209	1,425	1,650	1,451	500	974
67	1,209	1,425	1,650	1,451	500	974
68	1,222	1,440	1,668	1,468	506	1,009
69	1,249	1,473	1,707	1,501	517	1,050
70	1,282	1,512	1,752	1,541	531	1,091
71	1,321	1,557	1,805	1,587	547	1,128
72	1,363	1,606	1,861	1,636	564	1,168
73	1,407	1,658	1,922	1,690	582	1,206
74	1,456	1,717	1,989	1,748	603	1,248
75	1,506	1,777	2,059	1,809	624	1,288
76	1,560	1,838	2,131	1,874	646	1,329
77	1,614	1,902	2,206	1,939	668	1,374
78	1,669	1,967	2,280	2,005	691	1,420
79	1,721	2,030	2,352	2,068	713	1,465
80	1,776	2,093	2,426	2,134	735	1,514
81	1,831	2,159	2,503	2,200	758	1,561
82	1,886	2,223	2,577	2,266	781	1,608
83	1,943	2,292	2,655	2,336	805	1,658
84	2,001	2,358	2,734	2,403	829	1,706
85	2,073	2,444	2,834	2,491	859	1,768
86	2,133	2,515	2,914	2,562	883	1,819
87	2,193	2,585	2,998	2,634	908	1,870
88	2,254	2,659	3,080	2,709	934	1,923
89	2,318	2,732	3,166	2,784	960	1,976
90	2,382	2,807	3,254	2,861	986	2,030
91	2,446	2,883	3,342	2,938	1,013	2,085
92	2,512	2,960	3,431	3,018	1,040	2,141
93	2,579	3,040	3,523	3,098	1,068	2,199
94	2,647	3,120	3,617	3,180	1,096	2,257
95	2,716	3,201	3,710	3,264	1,125	2,316
96	2,786	3,284	3,807	3,348	1,154	2,375
97	2,857	3,368	3,903	3,434	1,183	2,437
98	2,930	3,453	4,002	3,520	1,213	2,498
99+	3,003	3,540	4,103	3,608	1,244	2,560

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	5,675	6,686	7,751	6,816	2,349	4,848
65	1,343	1,583	1,834	1,614	556	1,083
66	1,343	1,583	1,834	1,614	556	1,083
67	1,343	1,583	1,834	1,614	556	1,083
68	1,357	1,600	1,853	1,631	562	1,121
69	1,388	1,636	1,897	1,667	574	1,167
70	1,425	1,680	1,946	1,711	590	1,213
71	1,468	1,730	2,005	1,763	608	1,254
72	1,514	1,784	2,069	1,818	627	1,298
73	1,563	1,841	2,134	1,877	647	1,341
74	1,618	1,908	2,211	1,942	670	1,386
75	1,674	1,974	2,287	2,011	693	1,431
76	1,733	2,042	2,367	2,081	718	1,477
77	1,793	2,115	2,451	2,154	742	1,527
78	1,855	2,187	2,533	2,228	768	1,578
79	1,912	2,255	2,614	2,298	792	1,629
80	1,973	2,326	2,696	2,370	817	1,683
81	2,035	2,399	2,781	2,445	842	1,735
82	2,095	2,470	2,863	2,518	868	1,787
83	2,159	2,546	2,952	2,596	894	1,842
84	2,224	2,620	3,037	2,671	921	1,895
85	2,304	2,716	3,148	2,769	954	1,965
86	2,370	2,794	3,237	2,846	981	2,021
87	2,437	2,872	3,330	2,928	1,009	2,078
88	2,505	2,954	3,424	3,009	1,038	2,136
89	2,576	3,035	3,519	3,093	1,067	2,195
90	2,647	3,118	3,616	3,179	1,096	2,256
91	2,718	3,204	3,713	3,266	1,126	2,317
92	2,791	3,290	3,813	3,353	1,156	2,380
93	2,866	3,378	3,915	3,442	1,187	2,443
94	2,941	3,466	4,018	3,534	1,218	2,507
95	3,017	3,557	4,122	3,626	1,250	2,573
96	3,096	3,649	4,229	3,720	1,282	2,640
97	3,175	3,742	4,337	3,815	1,314	2,707
98	3,256	3,837	4,447	3,911	1,348	2,776
99+	3,336	3,933	4,558	4,009	1,382	2,845

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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 Period, use Preferred rates.

Aetna Health Insurance Company

Annual Premiums
For Use in: Rest of State
Male Rates

Rates Effective 03/1/2022

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	5,873	6,920	8,022	7,053	2,431	5,018
65	1,390	1,638	1,898	1,669	575	1,121
66	1,390	1,638	1,898	1,669	575	1,121
67	1,390	1,638	1,898	1,669	575	1,121
68	1,406	1,655	1,918	1,688	582	1,161
69	1,437	1,694	1,963	1,727	595	1,208
70	1,474	1,739	2,014	1,772	611	1,254
71	1,518	1,790	2,075	1,824	629	1,298
72	1,566	1,848	2,140	1,881	649	1,343
73	1,618	1,906	2,209	1,942	669	1,387
74	1,675	1,974	2,289	2,011	693	1,435
75	1,733	2,043	2,367	2,081	718	1,481
76	1,794	2,114	2,451	2,154	743	1,529
77	1,856	2,188	2,536	2,230	768	1,580
78	1,919	2,263	2,623	2,306	795	1,633
79	1,978	2,335	2,705	2,380	820	1,685
80	2,042	2,408	2,790	2,454	845	1,741
81	2,106	2,483	2,879	2,531	872	1,795
82	2,168	2,556	2,963	2,605	898	1,849
83	2,236	2,636	3,054	2,686	926	1,906
84	2,301	2,711	3,144	2,764	953	1,961
85	2,384	2,810	3,258	2,864	988	2,033
86	2,454	2,891	3,351	2,947	1,015	2,091
87	2,521	2,972	3,447	3,030	1,044	2,151
88	2,592	3,057	3,544	3,116	1,074	2,211
89	2,665	3,140	3,643	3,201	1,104	2,272
90	2,738	3,227	3,742	3,290	1,134	2,335
91	2,813	3,315	3,843	3,379	1,165	2,398
92	2,889	3,404	3,946	3,471	1,196	2,463
93	2,967	3,496	4,052	3,563	1,228	2,528
94	3,043	3,588	4,159	3,657	1,260	2,596
95	3,123	3,681	4,267	3,754	1,294	2,663
96	3,205	3,778	4,379	3,851	1,327	2,732
97	3,285	3,873	4,489	3,948	1,360	2,802
98	3,369	3,971	4,603	4,048	1,395	2,872
99+	3,454	4,071	4,719	1,431	1,431	2,944

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	6,525	7,690	8,914	7,839	2,701	5,575
65	1,545	1,820	2,109	1,854	639	1,245
66	1,545	1,820	2,109	1,854	639	1,245
67	1,545	1,820	2,109	1,854	639	1,245
68	1,561	1,840	2,131	1,876	646	1,290
69	1,596	1,882	2,181	1,917	660	1,342
70	1,638	1,931	2,238	1,968	679	1,395
71	1,688	1,988	2,305	2,028	699	1,442
72	1,741	2,051	2,379	2,091	721	1,492
73	1,797	2,118	2,455	2,158	744	1,541
74	1,860	2,193	2,543	2,234	771	1,594
75	1,925	2,270	2,630	2,312	797	1,645
76	1,993	2,348	2,723	2,394	826	1,698
77	2,061	2,431	2,819	2,478	853	1,756
78	2,133	2,515	2,914	2,562	883	1,815
79	2,199	2,593	3,005	2,643	911	1,873
80	2,268	2,675	3,101	2,726	940	1,935
81	2,340	2,760	3,197	2,812	968	1,995
82	2,410	2,841	3,293	2,895	998	2,055
83	2,483	2,928	3,394	2,985	1,028	2,118
84	2,557	3,014	3,492	3,072	1,059	2,179
85	2,650	3,123	3,620	3,183	1,097	2,259
86	2,725	3,212	3,723	3,273	1,128	2,323
87	2,802	3,303	3,829	3,366	1,160	2,390
88	2,881	3,396	3,937	3,461	1,194	2,456
89	2,962	3,490	4,046	3,558	1,227	2,525
90	3,043	3,586	4,158	3,656	1,260	2,594
91	3,125	3,683	4,270	3,756	1,295	2,664
92	3,210	3,782	4,385	3,856	1,329	2,736
93	3,295	3,884	4,503	3,959	1,365	2,809
94	3,382	3,986	4,621	4,064	1,401	2,884
95	3,469	4,090	4,740	4,171	1,438	2,959
96	3,561	4,197	4,865	4,278	1,474	3,036
97	3,652	4,303	4,988	4,387	1,511	3,113
98	3,744	4,412	5,115	4,497	1,550	3,192
99+	3,837	4,522	5,242	4,610	1,589	3,272

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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 Period, use Preferred rates.

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, KY 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 $1,556	$0	$1,556 (Part A Deductible)
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	$0	Up to $194.50 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 $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$0	$233 (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 $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	$0	Up to $194.50 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 $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$0	$233 (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 $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
• While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 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 $233 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 test, durable medical equipment			
First $233 of Medicare-Approved amounts*	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$233 (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 $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 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 services	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 $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$0	$233 (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 $2,490 deductible. Benefits from high deductible plan G will not begin until out-of-pocket expenses are $2,490. 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 $2,490 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
*While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 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 $233 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 $2,490 deductible. Benefits from high deductible plan G will not begin until out-of-pocket expenses are $2,490. 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 $2,490 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,490 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $2,490 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
*Medically necessary skilled care services and medical supplies	100%	$0	$0
*Durable medical equipment			
First $233 of Medicare Approved amounts	$0	$0	$233 (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 $2,490 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,490 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 $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
*While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 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 services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ 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 $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 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.
Part B Excess Charges (Above Medicare-Approved amounts)	$0	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare Approved amounts	$0	$0	$233 (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