Outline of coverage

Medicare Supplement Insurance

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

Underwritten by

Aetna Health Insurance Company

Oklahoma

aetnaseniorproducts.com

AHCMS04766OK

©2018 Aetna Inc.

Rates effective: 04/2019 A

AETNA HEALTH INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 2
BENEFIT PLANS AVAILABLE: A, B, F, HIGH DEDUCTIBLE F, G, N

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan “A”. Some plans may not be available in your state.

See Outlines of Coverage sections for details about ALL Plans

Basic Benefits:
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-Approved expenses) or, co-payments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of coinsurance or copayments
Blood: First three pints of blood each year.
Hospice: Part A coinsurance

A	B	C	D	F/F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $5560; paid at 100% after limit reached	Out-of-pocket limit $2780; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2300. 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.

Aetna Health Insurance Company

Annual Premiums

For Use in ZIP Codes: 730-731, 741

Female Rates

Rates Effective 4/1/2019

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,385	---	---	---	---	---
65	1,385	1,312	1,584	572	1,313	970
66	1,385	1,312	1,584	572	1,313	970
67	1,385	1,312	1,584	572	1,313	970
68	1,400	1,326	1,602	579	1,327	1,004
69	1,431	1,356	1,638	592	1,358	1,045
70	1,469	1,392	1,682	608	1,393	1,085
71	1,513	1,434	1,732	626	1,435	1,124
72	1,561	1,479	1,786	646	1,480	1,162
73	1,611	1,527	1,845	666	1,528	1,201
74	1,669	1,580	1,909	690	1,582	1,242
75	1,727	1,635	1,976	714	1,637	1,282
76	1,787	1,692	2,046	739	1,695	1,323
77	1,850	1,753	2,117	765	1,754	1,367
78	1,913	1,812	2,189	791	1,814	1,414
79	1,972	1,868	2,257	815	1,871	1,459
80	2,035	1,928	2,328	841	1,930	1,508
81	2,098	1,988	2,402	868	1,990	1,555
82	2,161	2,047	2,473	893	2,050	1,602
83	2,228	2,110	2,550	921	2,112	1,650
84	2,293	2,172	2,624	948	2,174	1,699
85	2,376	2,251	2,719	983	2,253	1,760
86	2,444	2,316	2,797	1,011	2,318	1,811
87	2,513	2,380	2,876	1,039	2,384	1,862
88	2,583	2,447	2,957	1,068	2,451	1,914
89	2,655	2,515	3,039	1,098	2,519	1,968
90	2,728	2,584	3,122	1,129	2,588	2,022
91	2,803	2,655	3,208	1,159	2,658	2,077
92	2,878	2,727	3,294	1,190	2,729	2,133
93	2,955	2,799	3,381	1,223	2,803	2,189
94	3,033	2,873	3,471	1,254	2,876	2,247
95	3,111	2,948	3,562	1,287	2,952	2,306
96	3,192	3,024	3,654	1,320	3,027	2,365
97	3,273	3,102	3,748	1,354	3,105	2,426
98	3,357	3,180	3,842	1,388	3,184	2,487
99+	3,440	3,259	3,938	1,422	3,263	2,550

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,538	---	---	---	---	---
65	1,538	1,458	1,760	636	1,459	1,078
66	1,538	1,458	1,760	636	1,459	1,078
67	1,538	1,458	1,760	636	1,459	1,078
68	1,555	1,473	1,780	644	1,475	1,116
69	1,590	1,508	1,821	658	1,509	1,162
70	1,632	1,547	1,868	676	1,548	1,206
71	1,682	1,594	1,925	696	1,595	1,250
72	1,734	1,643	1,985	717	1,644	1,292
73	1,791	1,697	2,050	741	1,698	1,335
74	1,854	1,756	2,121	767	1,758	1,380
75	1,919	1,817	2,196	793	1,819	1,425
76	1,986	1,880	2,272	821	1,882	1,470
77	2,055	1,947	2,352	850	1,948	1,520
78	2,125	2,013	2,432	878	2,016	1,570
79	2,191	2,076	2,508	906	2,078	1,621
80	2,260	2,142	2,588	935	2,145	1,675
81	2,332	2,210	2,669	964	2,212	1,728
82	2,401	2,274	2,748	993	2,278	1,780
83	2,475	2,345	2,833	1,024	2,347	1,834
84	2,548	2,413	2,916	1,054	2,416	1,888
85	2,640	2,501	3,022	1,092	2,503	1,956
86	2,715	2,573	3,108	1,123	2,575	2,012
87	2,793	2,645	3,196	1,155	2,648	2,069
88	2,871	2,719	3,285	1,187	2,723	2,127
89	2,949	2,795	3,377	1,220	2,798	2,186
90	3,032	2,872	3,469	1,254	2,875	2,246
91	3,114	2,949	3,564	1,287	2,953	2,308
92	3,198	3,030	3,660	1,322	3,033	2,370
93	3,283	3,110	3,757	1,359	3,114	2,432
94	3,370	3,192	3,857	1,393	3,196	2,497
95	3,457	3,276	3,957	1,430	3,280	2,562
96	3,547	3,360	4,060	1,467	3,363	2,628
97	3,637	3,446	4,164	1,504	3,450	2,696
98	3,729	3,533	4,268	1,542	3,538	2,764
99+	3,822	3,621	4,375	1,580	3,626	2,833

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

Aetna Health Insurance Company

Annual Premiums

For Use in ZIP Codes: 730-731, 741

Male Rates

Rates Effective 4/1/2019

Attained	Preferred						Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,592	---	---	---	---	---	Under 65	1,769	---	---	---	---	---
65	1,592	1,509	1,822	659	1,510	1,116	65	1,769	1,677	2,025	731	1,678	1,240
66	1,592	1,509	1,822	659	1,510	1,116	66	1,769	1,677	2,025	731	1,678	1,240
67	1,592	1,509	1,822	659	1,510	1,116	67	1,769	1,677	2,025	731	1,678	1,240
68	1,609	1,525	1,841	665	1,526	1,156	68	1,788	1,695	2,047	740	1,697	1,283
69	1,646	1,560	1,885	680	1,562	1,202	69	1,828	1,733	2,094	756	1,736	1,336
70	1,689	1,601	1,934	699	1,603	1,248	70	1,877	1,779	2,149	778	1,780	1,388
71	1,740	1,649	1,993	720	1,650	1,293	71	1,934	1,833	2,213	800	1,835	1,437
72	1,795	1,700	2,054	743	1,702	1,336	72	1,995	1,889	2,283	825	1,890	1,485
73	1,853	1,756	2,121	767	1,757	1,381	73	2,060	1,952	2,358	852	1,953	1,535
74	1,919	1,817	2,196	794	1,820	1,429	74	2,133	2,020	2,440	882	2,022	1,588
75	1,986	1,880	2,273	821	1,882	1,474	75	2,208	2,089	2,525	912	2,092	1,638
76	2,055	1,946	2,352	850	1,948	1,522	76	2,284	2,162	2,614	944	2,164	1,690
77	2,128	2,015	2,434	879	2,017	1,572	77	2,363	2,239	2,705	977	2,241	1,747
78	2,200	2,084	2,517	909	2,087	1,625	78	2,444	2,316	2,797	1,010	2,319	1,806
79	2,268	2,149	2,596	937	2,151	1,678	79	2,520	2,387	2,884	1,042	2,390	1,864
80	2,340	2,217	2,677	968	2,219	1,733	80	2,600	2,462	2,975	1,076	2,467	1,927
81	2,413	2,286	2,763	999	2,289	1,788	81	2,682	2,541	3,069	1,109	2,543	1,987
82	2,485	2,353	2,845	1,027	2,358	1,841	82	2,760	2,616	3,160	1,142	2,619	2,047
83	2,562	2,427	2,932	1,059	2,429	1,898	83	2,847	2,697	3,257	1,177	2,699	2,109
84	2,636	2,498	3,019	1,091	2,500	1,954	84	2,930	2,775	3,353	1,212	2,779	2,171
85	2,732	2,589	3,128	1,131	2,591	2,025	85	3,036	2,876	3,475	1,256	2,879	2,250
86	2,810	2,663	3,217	1,162	2,665	2,083	86	3,122	2,958	3,575	1,292	2,961	2,313
87	2,890	2,738	3,307	1,194	2,741	2,142	87	3,212	3,041	3,675	1,327	3,046	2,379
88	2,971	2,814	3,401	1,228	2,818	2,201	88	3,302	3,128	3,778	1,365	3,131	2,445
89	3,053	2,892	3,495	1,264	2,897	2,263	89	3,392	3,214	3,884	1,404	3,218	2,514
90	3,137	2,972	3,591	1,298	2,975	2,325	90	3,486	3,303	3,990	1,442	3,306	2,583
91	3,223	3,053	3,689	1,333	3,056	2,388	91	3,580	3,392	4,099	1,481	3,396	2,655
92	3,310	3,136	3,789	1,368	3,138	2,453	92	3,677	3,485	4,209	1,521	3,487	2,725
93	3,398	3,219	3,889	1,406	3,223	2,517	93	3,776	3,577	4,321	1,563	3,580	2,797
94	3,487	3,304	3,992	1,442	3,307	2,584	94	3,875	3,671	4,436	1,603	3,675	2,872
95	3,578	3,391	4,096	1,481	3,394	2,651	95	3,975	3,767	4,551	1,645	3,772	2,946
96	3,671	3,478	4,201	1,517	3,481	2,721	96	4,079	3,864	4,669	1,687	3,867	3,022
97	3,765	3,567	4,310	1,557	3,570	2,790	97	4,183	3,964	4,789	1,730	3,967	3,100
98	3,860	3,657	4,418	1,596	3,661	2,860	98	4,289	4,063	4,909	1,773	4,068	3,178
99+	3,956	3,749	4,528	1,636	3,752	2,932	99+	4,396	4,164	5,032	1,817	4,170	3,257

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

Aetna Health Insurance Company

Annual Premiums

For Use in: Rest of State

Female Rates

Rates Effective 4/1/2019

Attained	Preferred						Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,282	---	---	---	---	---	Under 65	1,424	---	---	---	---	---
65	1,282	1,215	1,467	530	1,216	898	65	1,424	1,350	1,630	589	1,351	998
66	1,282	1,215	1,467	530	1,216	898	66	1,424	1,350	1,630	589	1,351	998
67	1,282	1,215	1,467	530	1,216	898	67	1,424	1,350	1,630	589	1,351	998
68	1,296	1,228	1,483	536	1,229	930	68	1,440	1,364	1,648	596	1,366	1,033
69	1,325	1,256	1,517	548	1,257	968	69	1,472	1,396	1,686	609	1,397	1,076
70	1,360	1,289	1,557	563	1,290	1,005	70	1,511	1,432	1,730	626	1,433	1,117
71	1,401	1,328	1,604	580	1,329	1,041	71	1,557	1,476	1,782	644	1,477	1,157
72	1,445	1,369	1,654	598	1,370	1,076	72	1,606	1,521	1,838	664	1,522	1,196
73	1,492	1,414	1,708	617	1,415	1,112	73	1,658	1,571	1,898	686	1,572	1,236
74	1,545	1,463	1,768	639	1,465	1,150	74	1,717	1,626	1,964	710	1,628	1,278
75	1,599	1,514	1,830	661	1,516	1,187	75	1,777	1,682	2,033	734	1,684	1,319
76	1,655	1,567	1,894	684	1,569	1,225	76	1,839	1,741	2,104	760	1,743	1,361
77	1,713	1,623	1,960	708	1,624	1,266	77	1,903	1,803	2,178	787	1,804	1,407
78	1,771	1,678	2,027	732	1,680	1,309	78	1,968	1,864	2,252	813	1,867	1,454
79	1,826	1,730	2,090	755	1,732	1,351	79	2,029	1,922	2,322	839	1,924	1,501
80	1,884	1,785	2,156	779	1,787	1,396	80	2,093	1,983	2,396	866	1,986	1,551
81	1,943	1,841	2,224	804	1,843	1,440	81	2,159	2,046	2,471	893	2,048	1,600
82	2,001	1,895	2,290	827	1,898	1,483	82	2,223	2,106	2,544	919	2,109	1,648
83	2,063	1,954	2,361	853	1,956	1,528	83	2,292	2,171	2,623	948	2,173	1,698
84	2,123	2,011	2,430	878	2,013	1,573	84	2,359	2,234	2,700	976	2,237	1,748
85	2,200	2,084	2,518	910	2,086	1,630	85	2,444	2,316	2,798	1,011	2,318	1,811
86	2,263	2,144	2,590	936	2,146	1,677	86	2,514	2,382	2,878	1,040	2,384	1,863
87	2,327	2,204	2,663	962	2,207	1,724	87	2,586	2,449	2,959	1,069	2,452	1,916
88	2,392	2,266	2,738	989	2,269	1,772	88	2,658	2,518	3,042	1,099	2,521	1,969
89	2,458	2,329	2,814	1,017	2,332	1,822	89	2,731	2,588	3,127	1,130	2,591	2,024
90	2,526	2,393	2,891	1,045	2,396	1,872	90	2,807	2,659	3,212	1,161	2,662	2,080
91	2,595	2,458	2,970	1,073	2,461	1,923	91	2,883	2,731	3,300	1,192	2,734	2,137
92	2,665	2,525	3,050	1,102	2,527	1,975	92	2,961	2,806	3,389	1,224	2,808	2,194
93	2,736	2,592	3,131	1,132	2,595	2,027	93	3,040	2,880	3,479	1,258	2,883	2,252
94	2,808	2,660	3,214	1,161	2,663	2,081	94	3,120	2,956	3,571	1,290	2,959	2,312
95	2,881	2,730	3,298	1,192	2,733	2,135	95	3,201	3,033	3,664	1,324	3,037	2,372
96	2,956	2,800	3,383	1,222	2,803	2,190	96	3,284	3,111	3,759	1,358	3,114	2,433
97	3,031	2,872	3,470	1,254	2,875	2,246	97	3,368	3,191	3,856	1,393	3,194	2,496
98	3,108	2,944	3,557	1,285	2,948	2,303	98	3,453	3,271	3,952	1,428	3,276	2,559
99+	3,185	3,018	3,646	1,317	3,021	2,361	99+	3,539	3,353	4,051	1,463	3,357	2,623

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

Aetna Health Insurance Company

Annual Premiums

For Use in: Rest of State

Male Rates

Rates Effective 4/1/2019

Attained	Preferred						Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,474	---	---	---	---	---	Under 65	1,638	---	---	---	---	---
65	1,474	1,397	1,687	610	1,398	1,033	65	1,638	1,553	1,875	677	1,554	1,148
66	1,474	1,397	1,687	610	1,398	1,033	66	1,638	1,553	1,875	677	1,554	1,148
67	1,474	1,397	1,687	610	1,398	1,033	67	1,638	1,553	1,875	677	1,554	1,148
68	1,490	1,412	1,705	616	1,413	1,070	68	1,656	1,569	1,895	685	1,571	1,188
69	1,524	1,444	1,745	630	1,446	1,113	69	1,693	1,605	1,939	700	1,607	1,237
70	1,564	1,482	1,791	647	1,484	1,156	70	1,738	1,647	1,990	720	1,648	1,285
71	1,611	1,527	1,845	667	1,528	1,197	71	1,791	1,697	2,049	741	1,699	1,331
72	1,662	1,574	1,902	688	1,576	1,237	72	1,847	1,749	2,114	764	1,750	1,375
73	1,716	1,626	1,964	710	1,627	1,279	73	1,907	1,807	2,183	789	1,808	1,421
74	1,777	1,682	2,033	735	1,685	1,323	74	1,975	1,870	2,259	817	1,872	1,470
75	1,839	1,741	2,105	760	1,743	1,365	75	2,044	1,934	2,338	844	1,937	1,517
76	1,903	1,802	2,178	787	1,804	1,409	76	2,115	2,002	2,420	874	2,004	1,565
77	1,970	1,866	2,254	814	1,868	1,456	77	2,188	2,073	2,505	905	2,075	1,618
78	2,037	1,930	2,331	842	1,932	1,505	78	2,263	2,144	2,590	935	2,147	1,672
79	2,100	1,990	2,404	868	1,992	1,554	79	2,333	2,210	2,670	965	2,213	1,726
80	2,167	2,053	2,479	896	2,055	1,605	80	2,407	2,280	2,755	996	2,284	1,784
81	2,234	2,117	2,558	925	2,119	1,656	81	2,483	2,353	2,842	1,027	2,355	1,840
82	2,301	2,179	2,634	951	2,183	1,705	82	2,556	2,422	2,926	1,057	2,425	1,895
83	2,372	2,247	2,715	981	2,249	1,757	83	2,636	2,497	3,016	1,090	2,499	1,953
84	2,441	2,313	2,795	1,010	2,315	1,809	84	2,713	2,569	3,105	1,122	2,573	2,010
85	2,530	2,397	2,896	1,047	2,399	1,875	85	2,811	2,663	3,218	1,163	2,666	2,083
86	2,602	2,466	2,979	1,076	2,468	1,929	86	2,891	2,739	3,310	1,196	2,742	2,142
87	2,676	2,535	3,062	1,106	2,538	1,983	87	2,974	2,816	3,403	1,229	2,820	2,203
88	2,751	2,606	3,149	1,137	2,609	2,038	88	3,057	2,896	3,498	1,264	2,899	2,264
89	2,827	2,678	3,236	1,170	2,682	2,095	89	3,141	2,976	3,596	1,300	2,980	2,328
90	2,905	2,752	3,325	1,202	2,755	2,153	90	3,228	3,058	3,694	1,335	3,061	2,392
91	2,984	2,827	3,416	1,234	2,830	2,211	91	3,315	3,141	3,795	1,371	3,144	2,458
92	3,065	2,904	3,508	1,267	2,906	2,271	92	3,405	3,227	3,897	1,408	3,229	2,523
93	3,146	2,981	3,601	1,302	2,984	2,331	93	3,496	3,312	4,001	1,447	3,315	2,590
94	3,229	3,059	3,696	1,335	3,062	2,393	94	3,588	3,399	4,107	1,484	3,403	2,659
95	3,313	3,140	3,793	1,371	3,143	2,455	95	3,681	3,488	4,214	1,523	3,493	2,728
96	3,399	3,220	3,890	1,405	3,223	2,519	96	3,777	3,578	4,323	1,562	3,581	2,798
97	3,486	3,303	3,991	1,442	3,306	2,583	97	3,873	3,670	4,434	1,602	3,673	2,870
98	3,574	3,386	4,091	1,478	3,390	2,648	98	3,971	3,762	4,545	1,642	3,767	2,943
99+	3,663	3,471	4,193	1,515	3,474	2,715	99+	4,070	3,856	4,659	1,682	3,861	3,016

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

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 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 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, 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 $1364	$0	$1364 (Part A Deductible)
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	$0	Up to $170.50 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 $185 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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	$0	Up to $170.50 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 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 $185 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 $185 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	 $0 Generally 80%	 $0 Generally 20%	 $185 (Part B Deductible) $0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD First 3 pints Next $185 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 $185 (Part B Deductible) $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 $185 of Medicare Approved amounts*	 $0	 $0	 $185 (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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 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 $185 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 $185 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	 $0 Generally 80%	 $185 (Part B Deductible) Generally 20%	 $0 $0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD First 3 pints Next $185 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	 $0 $0 80%	 All costs $185 (Part B Deductible) 20%	 $0 $0 $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 $185 of Medicare Approved amounts*	 $0	 $185 (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 $2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2300. 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 $2300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2300 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 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 $185 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 $2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2300. 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 $2300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2300 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 $185 of Medicare-Approved amounts*	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$185 (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 $2300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2300 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment •First $185 of Medicare Approved amounts*	$0	$185 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2300 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2300 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 Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 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 $185 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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 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 $185 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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 •Durable medical equipment •First $185 of Medicare Approved amounts* •Remainder of Medicare Approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $185 (Part B Deductible) $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