Outline of coverage

Medicare Supplement Insurance

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

Colorado

Underwritten by

Aetna Health Insurance Company

AetnaSeniorProducts.com

AHCMS05034CO

Rates effective: 08/2023 B

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and High Deductible F.

Note: A ✓ means 100% of the benefit is paid.

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

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 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: 800-802
Female rates

Rates effective 8/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,014	3,270	4,400	896	3,332	2,045
65	2,010	2,181	2,933	597	2,219	1,364
66	2,010	2,181	2,933	597	2,219	1,364
67	2,010	2,181	2,933	597	2,219	1,364
68	2,029	2,205	2,964	603	2,245	1,413
69	2,072	2,250	3,031	618	2,294	1,469
70	2,127	2,307	3,104	633	2,349	1,522
71	2,192	2,381	3,200	651	2,424	1,577
72	2,262	2,452	3,303	673	2,501	1,633
73	2,337	2,535	3,410	695	2,581	1,687
74	2,414	2,622	3,524	718	2,669	1,742
75	2,502	2,715	3,653	745	2,766	1,802
76	2,590	2,809	3,782	770	2,862	1,859
77	2,681	2,907	3,914	798	2,963	1,920
78	2,772	3,009	4,048	824	3,063	1,985
79	2,862	3,105	4,181	852	3,165	2,052
80	2,953	3,205	4,309	878	3,265	2,120
81	3,044	3,306	4,448	906	3,367	2,188
82	3,138	3,409	4,586	935	3,474	2,255
83	3,239	3,515	4,727	963	3,579	2,326
84	3,337	3,622	4,871	992	3,688	2,397
85	3,448	3,745	5,034	1,026	3,810	2,477
86	3,547	3,849	5,179	1,055	3,919	2,546
87	3,645	3,957	5,322	1,085	4,031	2,618
88	3,749	4,068	5,474	1,115	4,144	2,693
89	3,853	4,182	5,625	1,147	4,261	2,766
90	3,958	4,297	5,780	1,177	4,376	2,843
91	4,067	4,416	5,939	1,210	4,496	2,920
92	4,175	4,532	6,100	1,242	4,616	2,999
93	4,287	4,654	6,261	1,275	4,739	3,079
94	4,402	4,778	6,426	1,310	4,864	3,161
95	4,517	4,902	6,595	1,342	4,991	3,243
96	4,634	5,027	6,765	1,379	5,123	3,328
97	4,752	5,158	6,937	1,414	5,252	3,413
98	4,873	5,288	7,113	1,449	5,387	3,500
99+	4,995	5,419	7,289	1,486	5,520	3,585

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,350	3,636	4,890	996	3,702	2,272
65	2,233	2,425	3,259	664	2,469	1,515
66	2,233	2,425	3,259	664	2,469	1,515
67	2,233	2,425	3,259	664	2,469	1,515
68	2,255	2,449	3,294	672	2,494	1,571
69	2,302	2,502	3,366	686	2,549	1,633
70	2,363	2,563	3,449	703	2,609	1,692
71	2,435	2,645	3,557	724	2,694	1,753
72	2,512	2,727	3,668	748	2,778	1,815
73	2,594	2,816	3,789	772	2,868	1,875
74	2,681	2,911	3,917	798	2,963	1,938
75	2,779	3,016	4,060	827	3,072	2,001
76	2,878	3,122	4,201	857	3,180	2,066
77	2,980	3,233	4,348	886	3,292	2,133
78	3,079	3,341	4,497	915	3,405	2,206
79	3,181	3,451	4,644	946	3,517	2,280
80	3,280	3,561	4,788	976	3,630	2,356
81	3,384	3,673	4,939	1,006	3,743	2,431
82	3,488	3,789	5,094	1,037	3,857	2,506
83	3,597	3,904	5,252	1,070	3,976	2,584
84	3,705	4,023	5,413	1,103	4,099	2,663
85	3,830	4,158	5,591	1,140	4,233	2,752
86	3,940	4,278	5,754	1,173	4,356	2,830
87	4,053	4,398	5,916	1,206	4,479	2,910
88	4,164	4,520	6,082	1,240	4,607	2,992
89	4,280	4,645	6,252	1,274	4,731	3,075
90	4,401	4,774	6,423	1,309	4,862	3,159
91	4,519	4,905	6,599	1,344	4,993	3,245
92	4,641	5,038	6,778	1,380	5,130	3,334
93	4,764	5,171	6,957	1,417	5,267	3,422
94	4,890	5,309	7,140	1,455	5,405	3,512
95	5,018	5,448	7,328	1,493	5,546	3,602
96	5,147	5,588	7,517	1,532	5,692	3,696
97	5,279	5,729	7,709	1,570	5,836	3,792
98	5,414	5,875	7,903	1,610	5,984	3,887
99+	5,547	6,022	8,101	1,651	6,134	3,983

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

To calculate the 7% Household discount:

Annual premium **x** modal factor**= modal premium** (round to nearest whole cent)
Modal premium **x** .93 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

Aetna Health Insurance Company
Annual premiums
For use in ZIP Codes: 800-802
Male rates

Rates effective 8/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,466	3,764	5,061	1,029	3,830	2,353
65	2,312	2,507	3,372	686	2,555	1,568
66	2,312	2,507	3,372	686	2,555	1,568
67	2,312	2,507	3,372	686	2,555	1,568
68	2,337	2,535	3,411	695	2,582	1,625
69	2,384	2,590	3,484	710	2,639	1,689
70	2,445	2,653	3,572	728	2,702	1,750
71	2,521	2,738	3,683	749	2,788	1,816
72	2,599	2,823	3,798	774	2,875	1,877
73	2,685	2,914	3,919	799	2,969	1,941
74	2,776	3,013	4,054	826	3,067	2,003
75	2,877	3,122	4,201	857	3,180	2,071
76	2,979	3,233	4,348	885	3,291	2,138
77	3,084	3,347	4,500	918	3,410	2,208
78	3,188	3,460	4,654	947	3,523	2,284
79	3,294	3,571	4,806	980	3,639	2,359
80	3,396	3,686	4,957	1,011	3,754	2,439
81	3,502	3,802	5,113	1,041	3,871	2,515
82	3,610	3,920	5,274	1,075	3,993	2,594
83	3,721	4,042	5,434	1,107	4,117	2,674
84	3,837	4,164	5,604	1,141	4,240	2,755
85	3,965	4,306	5,789	1,180	4,382	2,848
86	4,077	4,426	5,953	1,214	4,508	2,928
87	4,193	4,553	6,122	1,249	4,634	3,011
88	4,311	4,679	6,296	1,283	4,766	3,095
89	4,430	4,808	6,470	1,319	4,897	3,181
90	4,554	4,941	6,648	1,355	5,033	3,269
91	4,678	5,077	6,829	1,391	5,171	3,357
92	4,804	5,215	7,015	1,428	5,310	3,450
93	4,931	5,351	7,198	1,466	5,450	3,541
94	5,060	5,492	7,392	1,505	5,596	3,635
95	5,195	5,638	7,583	1,545	5,742	3,728
96	5,327	5,783	7,779	1,585	5,891	3,826
97	5,465	5,930	7,977	1,625	6,040	3,926
98	5,603	6,082	8,181	1,666	6,195	4,024
99+	5,744	6,233	8,382	1,709	6,345	4,123

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,853	4,182	5,622	1,145	4,259	2,613
65	2,570	2,789	3,748	763	2,836	1,741
66	2,570	2,789	3,748	763	2,836	1,741
67	2,570	2,789	3,748	763	2,836	1,741
68	2,594	2,816	3,791	773	2,869	1,807
69	2,650	2,877	3,870	790	2,931	1,877
70	2,719	2,948	3,969	808	3,002	1,945
71	2,802	3,043	4,089	833	3,098	2,016
72	2,888	3,136	4,219	861	3,195	2,086
73	2,983	3,240	4,357	887	3,298	2,157
74	3,084	3,348	4,505	918	3,410	2,228
75	3,195	3,470	4,669	953	3,535	2,302
76	3,310	3,593	4,832	984	3,657	2,375
77	3,425	3,717	5,001	1,020	3,788	2,453
78	3,540	3,844	5,172	1,053	3,915	2,537
79	3,657	3,970	5,338	1,089	4,043	2,623
80	3,772	4,096	5,509	1,121	4,172	2,710
81	3,892	4,224	5,682	1,157	4,302	2,794
82	4,012	4,356	5,858	1,193	4,436	2,883
83	4,135	4,489	6,040	1,229	4,573	2,972
84	4,262	4,626	6,226	1,268	4,712	3,062
85	4,405	4,784	6,431	1,311	4,868	3,164
86	4,531	4,919	6,617	1,348	5,009	3,254
87	4,659	5,058	6,803	1,387	5,149	3,345
88	4,789	5,198	6,997	1,426	5,299	3,440
89	4,925	5,343	7,190	1,464	5,443	3,535
90	5,059	5,490	7,388	1,504	5,591	3,634
91	5,197	5,640	7,589	1,546	5,744	3,732
92	5,337	5,792	7,796	1,587	5,901	3,833
93	5,478	5,945	7,999	1,628	6,058	3,936
94	5,624	6,104	8,211	1,674	6,215	4,037
95	5,771	6,265	8,426	1,716	6,379	4,144
96	5,921	6,427	8,645	1,763	6,544	4,252
97	6,073	6,590	8,864	1,805	6,711	4,361
98	6,224	6,757	9,091	1,851	6,879	4,471
99+	6,380	6,925	9,315	1,898	7,052	4,581

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

To calculate the 7% Household discount:

Annual premium **x** modal factor**= modal premium** (round to nearest whole cent)
Modal premium **x** .93 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

Aetna Health Insurance Company
Annual premiums
For use in: Rest of State
Female rates

Rates effective 8/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,667	2,894	3,894	793	2,949	1,810
65	1,779	1,930	2,596	528	1,964	1,207
66	1,779	1,930	2,596	528	1,964	1,207
67	1,779	1,930	2,596	528	1,964	1,207
68	1,796	1,951	2,623	534	1,987	1,250
69	1,834	1,991	2,682	547	2,030	1,300
70	1,882	2,042	2,747	560	2,079	1,347
71	1,940	2,107	2,832	576	2,145	1,396
72	2,002	2,170	2,923	596	2,213	1,445
73	2,068	2,243	3,018	615	2,284	1,493
74	2,136	2,320	3,119	635	2,362	1,542
75	2,214	2,403	3,233	659	2,448	1,595
76	2,292	2,486	3,347	681	2,533	1,645
77	2,373	2,573	3,464	706	2,622	1,699
78	2,453	2,663	3,582	729	2,711	1,757
79	2,533	2,748	3,700	754	2,801	1,816
80	2,613	2,836	3,813	777	2,889	1,876
81	2,694	2,926	3,936	802	2,980	1,936
82	2,777	3,017	4,058	827	3,074	1,996
83	2,866	3,111	4,183	852	3,167	2,058
84	2,953	3,205	4,311	878	3,264	2,121
85	3,051	3,314	4,455	908	3,372	2,192
86	3,139	3,406	4,583	934	3,468	2,253
87	3,226	3,502	4,710	960	3,567	2,317
88	3,318	3,600	4,844	987	3,667	2,383
89	3,410	3,701	4,978	1,015	3,771	2,448
90	3,503	3,803	5,115	1,042	3,873	2,516
91	3,599	3,908	5,256	1,071	3,979	2,584
92	3,695	4,011	5,398	1,099	4,085	2,654
93	3,794	4,119	5,541	1,128	4,194	2,725
94	3,896	4,228	5,687	1,159	4,304	2,797
95	3,997	4,338	5,836	1,188	4,417	2,870
96	4,101	4,449	5,987	1,220	4,534	2,945
97	4,205	4,565	6,139	1,251	4,648	3,020
98	4,312	4,680	6,295	1,282	4,767	3,097
99+	4,420	4,796	6,450	1,315	4,885	3,173

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,965	3,218	4,327	881	3,276	2,011
65	1,976	2,146	2,884	588	2,185	1,341
66	1,976	2,146	2,884	588	2,185	1,341
67	1,976	2,146	2,884	588	2,185	1,341
68	1,996	2,167	2,915	595	2,207	1,390
69	2,037	2,214	2,979	607	2,256	1,445
70	2,091	2,268	3,052	622	2,309	1,497
71	2,155	2,341	3,148	641	2,384	1,551
72	2,223	2,413	3,246	662	2,458	1,606
73	2,296	2,492	3,353	683	2,538	1,659
74	2,373	2,576	3,466	706	2,622	1,715
75	2,459	2,669	3,593	732	2,719	1,771
76	2,547	2,763	3,718	758	2,814	1,828
77	2,637	2,861	3,848	784	2,913	1,888
78	2,725	2,957	3,980	810	3,013	1,952
79	2,815	3,054	4,110	837	3,112	2,018
80	2,903	3,151	4,237	864	3,212	2,085
81	2,995	3,250	4,371	890	3,312	2,151
82	3,087	3,353	4,508	918	3,413	2,218
83	3,183	3,455	4,648	947	3,519	2,287
84	3,279	3,560	4,790	976	3,627	2,357
85	3,389	3,680	4,948	1,009	3,746	2,435
86	3,487	3,786	5,092	1,038	3,855	2,504
87	3,587	3,892	5,235	1,067	3,964	2,575
88	3,685	4,000	5,382	1,097	4,077	2,648
89	3,788	4,111	5,533	1,127	4,187	2,721
90	3,895	4,225	5,684	1,158	4,303	2,796
91	3,999	4,341	5,840	1,189	4,419	2,872
92	4,107	4,458	5,998	1,221	4,540	2,950
93	4,216	4,576	6,157	1,254	4,661	3,028
94	4,327	4,698	6,319	1,288	4,783	3,108
95	4,441	4,821	6,485	1,321	4,908	3,188
96	4,555	4,945	6,652	1,356	5,037	3,271
97	4,672	5,070	6,822	1,389	5,165	3,356
98	4,791	5,199	6,994	1,425	5,296	3,440
99+	4,909	5,329	7,169	1,461	5,428	3,525

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

To calculate the 7% Household discount:

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Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

Aetna Health Insurance Company
Annual premiums
For use in: Rest of State
Male rates

Rates effective 8/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,067	3,331	4,479	911	3,389	2,082
65	2,046	2,219	2,984	607	2,261	1,388
66	2,046	2,219	2,984	607	2,261	1,388
67	2,046	2,219	2,984	607	2,261	1,388
68	2,068	2,243	3,019	615	2,285	1,438
69	2,110	2,292	3,083	628	2,335	1,495
70	2,164	2,348	3,161	644	2,391	1,549
71	2,231	2,423	3,259	663	2,467	1,607
72	2,300	2,498	3,361	685	2,544	1,661
73	2,376	2,579	3,468	707	2,627	1,718
74	2,457	2,666	3,588	731	2,714	1,773
75	2,546	2,763	3,718	758	2,814	1,833
76	2,636	2,861	3,848	783	2,912	1,892
77	2,729	2,962	3,982	812	3,018	1,954
78	2,821	3,062	4,119	838	3,118	2,021
79	2,915	3,160	4,253	867	3,220	2,088
80	3,005	3,262	4,387	895	3,322	2,158
81	3,099	3,365	4,525	921	3,426	2,226
82	3,195	3,469	4,667	951	3,534	2,296
83	3,293	3,577	4,809	980	3,643	2,366
84	3,396	3,685	4,959	1,010	3,752	2,438
85	3,509	3,811	5,123	1,044	3,878	2,520
86	3,608	3,917	5,268	1,074	3,989	2,591
87	3,711	4,029	5,418	1,105	4,101	2,665
88	3,815	4,141	5,572	1,135	4,218	2,739
89	3,920	4,255	5,726	1,167	4,334	2,815
90	4,030	4,373	5,883	1,199	4,454	2,893
91	4,140	4,493	6,043	1,231	4,576	2,971
92	4,251	4,615	6,208	1,264	4,699	3,053
93	4,364	4,735	6,370	1,297	4,823	3,134
94	4,478	4,860	6,542	1,332	4,952	3,217
95	4,597	4,989	6,711	1,367	5,081	3,299
96	4,714	5,118	6,884	1,403	5,213	3,386
97	4,836	5,248	7,059	1,438	5,345	3,474
98	4,958	5,382	7,240	1,474	5,482	3,561
99+	5,083	5,516	7,418	1,512	5,615	3,649

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,410	3,701	4,975	1,013	3,769	2,312
65	2,274	2,468	3,317	675	2,510	1,541
66	2,274	2,468	3,317	675	2,510	1,541
67	2,274	2,468	3,317	675	2,510	1,541
68	2,296	2,492	3,355	684	2,539	1,599
69	2,345	2,546	3,425	699	2,594	1,661
70	2,406	2,609	3,512	715	2,657	1,721
71	2,480	2,693	3,619	737	2,742	1,784
72	2,556	2,775	3,734	762	2,827	1,846
73	2,640	2,867	3,856	785	2,919	1,909
74	2,729	2,963	3,987	812	3,018	1,972
75	2,827	3,071	4,132	843	3,128	2,037
76	2,929	3,180	4,276	871	3,236	2,102
77	3,031	3,289	4,426	903	3,352	2,171
78	3,133	3,402	4,577	932	3,465	2,245
79	3,236	3,513	4,724	964	3,578	2,321
80	3,338	3,625	4,875	992	3,692	2,398
81	3,444	3,738	5,028	1,024	3,807	2,473
82	3,550	3,855	5,184	1,056	3,926	2,551
83	3,659	3,973	5,345	1,088	4,047	2,630
84	3,772	4,094	5,510	1,122	4,170	2,710
85	3,898	4,234	5,691	1,160	4,308	2,800
86	4,010	4,353	5,856	1,193	4,433	2,880
87	4,123	4,476	6,020	1,227	4,557	2,960
88	4,238	4,600	6,192	1,262	4,689	3,044
89	4,358	4,728	6,363	1,296	4,817	3,128
90	4,477	4,858	6,538	1,331	4,948	3,216
91	4,599	4,991	6,716	1,368	5,083	3,303
92	4,723	5,126	6,899	1,404	5,222	3,392
93	4,848	5,261	7,079	1,441	5,361	3,483
94	4,977	5,402	7,266	1,481	5,500	3,573
95	5,107	5,544	7,457	1,519	5,645	3,667
96	5,240	5,688	7,650	1,560	5,791	3,763
97	5,374	5,832	7,844	1,597	5,939	3,859
98	5,508	5,980	8,045	1,638	6,088	3,957
99+	5,646	6,128	8,243	1,680	6,241	4,054

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

To calculate the 7% Household discount:

Annual premium **x** modal factor**= modal premium** (round to nearest whole cent)
Modal premium **x** .93 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

PREMIUM INFORMATION

Aetna Health Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state. Premiums for this policy will increase due to the increase in your age. Upon attainment of an age requiring a rate increase, the renewal premium for the policy will be the renewal premium then in effect for your attained age. Other policies may be provided with Issue Age rating and do not increase with age. You should compare Issue Age with Attained Age policies.

Premiums payable other than annually will be determined according to the following factors:

Semi-annual: 0.5200 Quarterly: 0.2650 Monthly EFT: 0.0833.

HOUSEHOLD DISCOUNT

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

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Aetna Health Insurance Company, P.O. Box 14770, Lexington, Kentucky 40512-4770. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do **NOT** cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

The policy may not cover all of your medical costs. Neither Aetna Health Insurance Company nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare & You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

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

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$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

HIGH DEDUCTIBLE PLAN F

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

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

****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,800 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 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 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.

****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,800 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 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	$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

HIGH DEDUCTIBLE PLAN F

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	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 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 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

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