Aetna Health and Life Insurance Company

Administrative Office
800 Crescent Centre Dr.
Suite 200
Franklin, TN 37067
800 264.4000
aetnaseniorproducts.com

Outline of Coverage

Medicare Supplement Insurance

BENEFIT PLANS A, B, F, High Deductible F, G, N

Underwritten by

Aetna Health and Life Insurance Company

Nebraska

AETNA HEALTH AND LIFE 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, copayments 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 $4960; paid at 100% after limit reached	Out-of-pocket limit $2480; paid at 100% after limit reached		

*Plans 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 $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2180. 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 and Life Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: 680-681

Female Rates

Attained	Preferred					
Age	Plan A	Plan B	Plan F	High F	Plan G	Plan N
65	1,254	1,315	1,537	615	1,293	950
66	1,279	1,348	1,576	630	1,325	975
67	1,305	1,382	1,616	646	1,360	999
68	1,332	1,417	1,657	663	1,394	1,025
69	1,360	1,453	1,698	679	1,430	1,050
70	1,388	1,490	1,742	696	1,465	1,077
71	1,414	1,543	1,804	722	1,517	1,116
72	1,443	1,597	1,868	747	1,572	1,154
73	1,473	1,654	1,935	774	1,627	1,195
74	1,504	1,713	2,004	800	1,685	1,239
75	1,535	1,774	2,075	829	1,746	1,283
76	1,567	1,838	2,148	859	1,808	1,329
77	1,600	1,903	2,224	890	1,871	1,375
78	1,633	1,972	2,305	922	1,939	1,425
79	1,667	2,042	2,389	956	2,009	1,476
80	1,703	2,116	2,474	990	2,082	1,530
81	1,737	2,190	2,562	1,025	2,155	1,583
82	1,772	2,264	2,648	1,060	2,228	1,637
83	1,810	2,344	2,742	1,097	2,307	1,695
84	1,849	2,425	2,836	1,134	2,387	1,754
85	1,884	2,500	2,923	1,169	2,459	1,807
86	1,916	2,573	3,008	1,203	2,531	1,859
87	1,948	2,644	3,092	1,238	2,602	1,911
88	1,980	2,716	3,177	1,271	2,673	1,964
89	2,011	2,788	3,260	1,304	2,743	2,016
90	2,041	2,858	3,341	1,336	2,812	2,066
91	2,072	2,926	3,421	1,369	2,879	2,116
92	2,101	2,994	3,501	1,400	2,946	2,165
93	2,131	3,059	3,578	1,432	3,009	2,211
94	2,159	3,122	3,652	1,462	3,072	2,258
95	2,187	3,186	3,725	1,490	3,134	2,302
96	2,213	3,246	3,794	1,517	3,192	2,345
97	2,239	3,301	3,862	1,544	3,248	2,387
98	2,263	3,357	3,926	1,571	3,303	2,426
99+	2,288	3,410	3,987	1,594	3,354	2,464

Attained	Standard					
Age	Plan A	Plan B	Plan F	High F	Plan G	Plan N
65	1,393	1,462	1,707	684	1,437	1,056
66	1,422	1,497	1,752	700	1,473	1,083
67	1,451	1,535	1,796	718	1,511	1,110
68	1,480	1,574	1,841	736	1,548	1,139
69	1,511	1,615	1,887	755	1,590	1,167
70	1,542	1,655	1,935	775	1,628	1,197
71	1,572	1,714	2,005	803	1,686	1,240
72	1,604	1,774	2,075	829	1,746	1,283
73	1,637	1,838	2,149	859	1,808	1,329
74	1,672	1,904	2,227	889	1,873	1,376
75	1,706	1,971	2,305	922	1,939	1,425
76	1,740	2,041	2,387	956	2,008	1,476
77	1,777	2,113	2,472	990	2,080	1,528
78	1,814	2,191	2,562	1,023	2,155	1,584
79	1,854	2,269	2,654	1,062	2,233	1,641
80	1,891	2,351	2,748	1,100	2,313	1,699
81	1,930	2,433	2,846	1,139	2,394	1,758
82	1,968	2,516	2,942	1,178	2,475	1,819
83	2,011	2,605	3,046	1,219	2,563	1,884
84	2,055	2,695	3,151	1,260	2,651	1,949
85	2,093	2,777	3,248	1,299	2,732	2,008
86	2,129	2,858	3,342	1,338	2,813	2,066
87	2,165	2,938	3,437	1,375	2,890	2,123
88	2,201	3,018	3,530	1,412	2,969	2,182
89	2,234	3,098	3,622	1,450	3,048	2,240
90	2,268	3,176	3,713	1,485	3,124	2,295
91	2,303	3,251	3,802	1,522	3,199	2,351
92	2,335	3,326	3,889	1,556	3,273	2,405
93	2,369	3,400	3,975	1,591	3,344	2,456
94	2,399	3,470	4,057	1,623	3,413	2,509
95	2,430	3,539	4,138	1,655	3,481	2,557
96	2,459	3,606	4,216	1,687	3,548	2,606
97	2,489	3,669	4,290	1,715	3,610	2,652
98	2,515	3,730	4,362	1,745	3,670	2,696
99+	2,542	3,788	4,431	1,772	3,727	2,738

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

The above rates do not include the $20 application 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 and Life Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: 680-681

Male Rates

Attained Age	Preferred					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
65	1,442	1,513	1,767	707	1,487	1,092
66	1,471	1,550	1,813	725	1,524	1,121
67	1,501	1,590	1,858	744	1,564	1,149
68	1,532	1,629	1,905	763	1,604	1,178
69	1,563	1,672	1,954	781	1,645	1,208
70	1,595	1,713	2,004	800	1,685	1,239
71	1,627	1,774	2,075	829	1,746	1,283
72	1,661	1,837	2,148	858	1,806	1,328
73	1,694	1,903	2,224	889	1,871	1,375
74	1,729	1,969	2,304	920	1,938	1,424
75	1,766	2,040	2,387	955	2,008	1,475
76	1,802	2,113	2,471	989	2,079	1,528
77	1,839	2,188	2,559	1,023	2,152	1,582
78	1,877	2,268	2,651	1,060	2,230	1,639
79	1,918	2,350	2,747	1,099	2,311	1,698
80	1,958	2,433	2,846	1,139	2,394	1,759
81	1,997	2,519	2,947	1,179	2,478	1,820
82	2,038	2,604	3,045	1,219	2,562	1,883
83	2,082	2,696	3,152	1,261	2,652	1,949
84	2,127	2,788	3,262	1,304	2,744	2,017
85	2,167	2,875	3,361	1,344	2,828	2,078
86	2,203	2,958	3,459	1,384	2,912	2,138
87	2,241	3,041	3,556	1,423	2,993	2,198
88	2,278	3,124	3,654	1,462	3,074	2,258
89	2,313	3,207	3,748	1,500	3,154	2,318
90	2,348	3,287	3,842	1,537	3,233	2,375
91	2,383	3,366	3,935	1,574	3,311	2,433
92	2,416	3,443	4,026	1,610	3,388	2,490
93	2,452	3,519	4,115	1,646	3,461	2,543
94	2,483	3,592	4,199	1,681	3,533	2,596
95	2,515	3,663	4,283	1,713	3,603	2,647
96	2,545	3,732	4,363	1,745	3,671	2,697
97	2,575	3,796	4,440	1,775	3,735	2,745
98	2,603	3,861	4,514	1,807	3,798	2,791
99+	2,631	3,922	4,585	1,834	3,857	2,834

Attained Age	Standard					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
65	1,602	1,681	1,964	786	1,653	1,214
66	1,635	1,722	2,014	806	1,694	1,245
67	1,668	1,766	2,066	826	1,737	1,277
68	1,702	1,810	2,117	846	1,782	1,310
69	1,737	1,857	2,170	869	1,828	1,342
70	1,773	1,904	2,224	890	1,873	1,376
71	1,808	1,972	2,305	922	1,939	1,426
72	1,845	2,040	2,387	955	2,008	1,475
73	1,884	2,113	2,472	989	2,079	1,528
74	1,921	2,189	2,561	1,022	2,155	1,583
75	1,961	2,267	2,651	1,060	2,230	1,639
76	2,002	2,348	2,745	1,099	2,310	1,698
77	2,042	2,430	2,843	1,139	2,392	1,758
78	2,086	2,520	2,947	1,178	2,478	1,822
79	2,131	2,610	3,053	1,222	2,567	1,887
80	2,176	2,703	3,161	1,265	2,661	1,955
81	2,220	2,799	3,272	1,310	2,753	2,022
82	2,263	2,894	3,383	1,353	2,847	2,092
83	2,313	2,996	3,503	1,403	2,948	2,167
84	2,363	3,099	3,624	1,450	3,049	2,241
85	2,408	3,195	3,734	1,493	3,141	2,309
86	2,448	3,287	3,843	1,538	3,235	2,375
87	2,490	3,380	3,953	1,582	3,324	2,442
88	2,531	3,472	4,059	1,624	3,414	2,510
89	2,571	3,563	4,165	1,666	3,505	2,576
90	2,609	3,652	4,270	1,708	3,593	2,640
91	2,648	3,740	4,372	1,749	3,679	2,704
92	2,685	3,824	4,472	1,789	3,764	2,766
93	2,724	3,909	4,571	1,829	3,846	2,825
94	2,758	3,989	4,665	1,867	3,925	2,885
95	2,794	4,070	4,760	1,904	4,004	2,942
96	2,828	4,147	4,850	1,939	4,079	2,997
97	2,862	4,219	4,934	1,974	4,151	3,049
98	2,893	4,289	5,017	2,007	4,221	3,100
99+	2,923	4,357	5,095	2,038	4,287	3,149

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

The above rates do not include the $20 application 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 and Life Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of State

Female Rates

Attained	Preferred					
Age	Plan A	Plan B	Plan F	High F	Plan G	Plan N
65	1,130	1,185	1,385	554	1,165	856
66	1,152	1,214	1,420	568	1,194	878
67	1,176	1,245	1,456	582	1,225	900
68	1,200	1,277	1,493	597	1,256	923
69	1,225	1,309	1,530	612	1,288	946
70	1,250	1,342	1,569	627	1,320	970
71	1,274	1,390	1,625	650	1,367	1,005
72	1,300	1,439	1,683	673	1,416	1,040
73	1,327	1,490	1,743	697	1,466	1,077
74	1,355	1,543	1,805	721	1,518	1,116
75	1,383	1,598	1,869	747	1,573	1,156
76	1,412	1,656	1,935	774	1,629	1,197
77	1,441	1,714	2,004	802	1,686	1,239
78	1,471	1,777	2,077	831	1,747	1,284
79	1,502	1,840	2,152	861	1,810	1,330
80	1,534	1,906	2,229	892	1,876	1,378
81	1,565	1,973	2,308	923	1,941	1,426
82	1,596	2,040	2,386	955	2,007	1,475
83	1,631	2,112	2,470	988	2,078	1,527
84	1,666	2,185	2,555	1,022	2,150	1,580
85	1,697	2,252	2,633	1,053	2,215	1,628
86	1,726	2,318	2,710	1,084	2,280	1,675
87	1,755	2,382	2,786	1,115	2,344	1,722
88	1,784	2,447	2,862	1,145	2,408	1,769
89	1,812	2,512	2,937	1,175	2,471	1,816
90	1,839	2,575	3,010	1,204	2,533	1,861
91	1,867	2,636	3,082	1,233	2,594	1,906
92	1,893	2,697	3,154	1,261	2,654	1,950
93	1,920	2,756	3,223	1,290	2,711	1,992
94	1,945	2,813	3,290	1,317	2,768	2,034
95	1,970	2,870	3,356	1,342	2,823	2,074
96	1,994	2,924	3,418	1,367	2,876	2,113
97	2,017	2,974	3,479	1,391	2,926	2,150
98	2,039	3,024	3,537	1,415	2,976	2,186
99+	2,061	3,072	3,592	1,436	3,022	2,220

Attained	Standard					
Age	Plan A	Plan B	Plan F	High F	Plan G	Plan N
65	1,255	1,317	1,538	616	1,295	951
66	1,281	1,349	1,578	631	1,327	976
67	1,307	1,383	1,618	647	1,361	1,000
68	1,333	1,418	1,659	663	1,395	1,026
69	1,361	1,455	1,700	680	1,432	1,051
70	1,389	1,491	1,743	698	1,467	1,078
71	1,416	1,544	1,806	723	1,519	1,117
72	1,445	1,598	1,869	747	1,573	1,156
73	1,475	1,656	1,936	774	1,629	1,197
74	1,506	1,715	2,006	801	1,687	1,240
75	1,537	1,776	2,077	831	1,747	1,284
76	1,568	1,839	2,150	861	1,809	1,330
77	1,601	1,904	2,227	892	1,874	1,377
78	1,634	1,974	2,308	922	1,941	1,427
79	1,670	2,044	2,391	957	2,012	1,478
80	1,704	2,118	2,476	991	2,084	1,531
81	1,739	2,192	2,564	1,026	2,157	1,584
82	1,773	2,267	2,650	1,061	2,230	1,639
83	1,812	2,347	2,744	1,098	2,309	1,697
84	1,851	2,428	2,839	1,135	2,388	1,756
85	1,886	2,502	2,926	1,170	2,461	1,809
86	1,918	2,575	3,011	1,205	2,534	1,861
87	1,950	2,647	3,096	1,239	2,604	1,913
88	1,983	2,719	3,180	1,272	2,675	1,966
89	2,013	2,791	3,263	1,306	2,746	2,018
90	2,043	2,861	3,345	1,338	2,814	2,068
91	2,075	2,929	3,425	1,371	2,882	2,118
92	2,104	2,996	3,504	1,402	2,949	2,167
93	2,134	3,063	3,581	1,433	3,013	2,213
94	2,161	3,126	3,655	1,462	3,075	2,260
95	2,189	3,188	3,728	1,491	3,136	2,304
96	2,215	3,249	3,798	1,520	3,196	2,348
97	2,242	3,305	3,865	1,545	3,252	2,389
98	2,266	3,360	3,930	1,572	3,306	2,429
99+	2,290	3,413	3,992	1,596	3,358	2,467

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

The above rates do not include the $20 application 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 and Life Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of State

Male Rates

Attained	Preferred					
Age	Plan A	Plan B	Plan F	High F	Plan G	Plan N
65	1,299	1,363	1,592	637	1,340	984
66	1,325	1,396	1,633	653	1,373	1,010
67	1,352	1,432	1,674	670	1,409	1,035
68	1,380	1,468	1,716	687	1,445	1,061
69	1,408	1,506	1,760	704	1,482	1,088
70	1,437	1,543	1,805	721	1,518	1,116
71	1,466	1,598	1,869	747	1,573	1,156
72	1,496	1,655	1,935	773	1,627	1,196
73	1,526	1,714	2,004	801	1,686	1,239
74	1,558	1,774	2,076	829	1,746	1,283
75	1,591	1,838	2,150	860	1,809	1,329
76	1,623	1,904	2,226	891	1,873	1,377
77	1,657	1,971	2,305	922	1,939	1,425
78	1,691	2,043	2,388	955	2,009	1,477
79	1,728	2,117	2,475	990	2,082	1,530
80	1,764	2,192	2,564	1,026	2,157	1,585
81	1,799	2,269	2,655	1,062	2,232	1,640
82	1,836	2,346	2,743	1,098	2,308	1,696
83	1,876	2,429	2,840	1,136	2,389	1,756
84	1,916	2,512	2,939	1,175	2,472	1,817
85	1,952	2,590	3,028	1,211	2,548	1,872
86	1,985	2,665	3,116	1,247	2,623	1,926
87	2,019	2,740	3,204	1,282	2,696	1,980
88	2,052	2,814	3,292	1,317	2,769	2,034
89	2,084	2,889	3,377	1,351	2,841	2,088
90	2,115	2,961	3,461	1,385	2,913	2,140
91	2,147	3,032	3,545	1,418	2,983	2,192
92	2,177	3,102	3,627	1,450	3,052	2,243
93	2,209	3,170	3,707	1,483	3,118	2,291
94	2,237	3,236	3,783	1,514	3,183	2,339
95	2,266	3,300	3,859	1,543	3,246	2,385
96	2,293	3,362	3,931	1,572	3,307	2,430
97	2,320	3,420	4,000	1,599	3,365	2,473
98	2,345	3,478	4,067	1,628	3,422	2,514
99+	2,370	3,533	4,131	1,652	3,475	2,553

Attained	Standard					
Age	Plan A	Plan B	Plan F	High F	Plan G	Plan N
65	1,443	1,514	1,769	708	1,489	1,094
66	1,473	1,551	1,814	726	1,526	1,122
67	1,503	1,591	1,861	744	1,565	1,150
68	1,533	1,631	1,907	762	1,605	1,180
69	1,565	1,673	1,955	783	1,647	1,209
70	1,597	1,715	2,004	802	1,687	1,240
71	1,629	1,777	2,077	831	1,747	1,285
72	1,662	1,838	2,150	860	1,809	1,329
73	1,697	1,904	2,227	891	1,873	1,377
74	1,731	1,972	2,307	921	1,941	1,426
75	1,767	2,042	2,388	955	2,009	1,477
76	1,804	2,115	2,473	990	2,081	1,530
77	1,840	2,189	2,561	1,026	2,155	1,584
78	1,879	2,270	2,655	1,061	2,232	1,641
79	1,920	2,351	2,750	1,101	2,313	1,700
80	1,960	2,435	2,848	1,140	2,397	1,761
81	2,000	2,522	2,948	1,180	2,480	1,822
82	2,039	2,607	3,048	1,219	2,565	1,885
83	2,084	2,699	3,156	1,264	2,656	1,952
84	2,129	2,792	3,265	1,306	2,747	2,019
85	2,169	2,878	3,364	1,345	2,830	2,080
86	2,205	2,961	3,462	1,386	2,914	2,140
87	2,243	3,045	3,561	1,425	2,995	2,200
88	2,280	3,128	3,657	1,463	3,076	2,261
89	2,316	3,210	3,752	1,501	3,158	2,321
90	2,350	3,290	3,847	1,539	3,237	2,378
91	2,386	3,369	3,939	1,576	3,314	2,436
92	2,419	3,445	4,029	1,612	3,391	2,492
93	2,454	3,522	4,118	1,648	3,465	2,545
94	2,485	3,594	4,203	1,682	3,536	2,599
95	2,517	3,667	4,288	1,715	3,607	2,650
96	2,548	3,736	4,369	1,747	3,675	2,700
97	2,578	3,801	4,445	1,778	3,740	2,747
98	2,606	3,864	4,520	1,808	3,803	2,793
99+	2,633	3,925	4,590	1,836	3,862	2,837

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

The above rates do not include the $20 application 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 and Life 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 and Life 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 Health and Life Insurance Company Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (b) be someone with whom you are in a civil union partnership; or (c) be a permanent resident in your home. 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 and Life Insurance Company, P.O. Box 1188, Brentwood, Tennessee 37024. 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 and Life 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 AND LIFE INSURANCE COMPANY.

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER CALENDAR YEAR

*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 $1288	$0	$1288 (Part A Deductible)
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	$0	Up to $161 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 $166 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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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 $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	$0	Up to $161 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 $166 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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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 $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	Up to $161 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 $166 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 $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$166 (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 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 $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2180. 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 $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	Up to $161 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 $166 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 $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2180. 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 $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 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 test, durable medical equipment			
First $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$166 (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 $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment •First $166 of Medicare Approved amounts*	$0	$166 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2180 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 $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	Up to $161 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 $166 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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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 $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	Up to $161 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 N

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

*Once you have been billed $166 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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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