aetna®

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

South Carolina

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, 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 $4960; paid at 100% after limit reached	Out-of-pocket limit $2480; 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 $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: 294-295, 299

Female Rates

Attained	Preferred					
Age	Plan A	Plan B	Plan F	High F	Plan G	Plan N
65	1,290	1,502	1,782	666	1,233	1,097
66	1,290	1,502	1,782	666	1,233	1,097
67	1,290	1,502	1,782	666	1,233	1,097
68	1,342	1,564	1,856	694	1,285	1,143
69	1,401	1,635	1,928	721	1,342	1,193
70	1,458	1,700	1,998	747	1,396	1,243
71	1,513	1,764	2,067	773	1,447	1,290
72	1,564	1,827	2,133	797	1,499	1,334
73	1,615	1,884	2,189	819	1,547	1,377
74	1,659	1,938	2,246	840	1,589	1,416
75	1,700	1,987	2,297	859	1,630	1,452
76	1,740	2,034	2,342	877	1,668	1,485
77	1,779	2,076	2,383	891	1,703	1,516
78	1,814	2,117	2,419	905	1,737	1,546
79	1,844	2,154	2,453	918	1,766	1,573
80	1,876	2,188	2,484	929	1,794	1,599
81	1,903	2,220	2,515	941	1,821	1,622
82	1,928	2,249	2,548	952	1,845	1,644
83	1,954	2,278	2,577	963	1,868	1,665
84	1,978	2,305	2,608	975	1,891	1,686
85	2,002	2,333	2,638	985	1,915	1,706
86	2,024	2,360	2,664	996	1,935	1,724
87	2,046	2,385	2,693	1,006	1,955	1,743
88	2,068	2,410	2,716	1,015	1,976	1,761
89	2,087	2,432	2,739	1,024	1,994	1,778
90	2,106	2,453	2,762	1,034	2,012	1,792
91	2,123	2,472	2,785	1,041	2,029	1,807
92	2,140	2,491	2,802	1,048	2,044	1,820
93	2,156	2,509	2,819	1,055	2,058	1,833
94	2,169	2,527	2,834	1,060	2,072	1,844
95	2,182	2,541	2,850	1,065	2,084	1,855
96	2,195	2,555	2,863	1,071	2,094	1,864
97	2,208	2,573	2,879	1,076	2,108	1,876
98	2,221	2,587	2,895	1,083	2,119	1,886
99+	2,235	2,603	2,908	1,087	2,133	1,897

Attained	Standard					
Age	Plan A	Plan B	Plan F	High F	Plan G	Plan N
65	1,433	1,670	1,980	740	1,370	1,218
66	1,433	1,670	1,980	740	1,370	1,218
67	1,433	1,670	1,980	740	1,370	1,218
68	1,492	1,739	2,061	771	1,426	1,269
69	1,558	1,817	2,142	802	1,490	1,326
70	1,622	1,889	2,220	830	1,550	1,378
71	1,682	1,961	2,298	858	1,609	1,431
72	1,740	2,028	2,369	886	1,665	1,480
73	1,796	2,095	2,433	910	1,718	1,528
74	1,847	2,155	2,495	934	1,767	1,571
75	1,894	2,208	2,551	954	1,811	1,610
76	1,937	2,260	2,603	973	1,853	1,648
77	1,978	2,308	2,647	990	1,894	1,683
78	2,017	2,352	2,688	1,004	1,930	1,717
79	2,052	2,393	2,726	1,020	1,963	1,746
80	2,085	2,432	2,759	1,032	1,995	1,773
81	2,116	2,467	2,794	1,046	2,025	1,799
82	2,143	2,501	2,830	1,060	2,051	1,824
83	2,170	2,532	2,863	1,072	2,079	1,847
84	2,198	2,564	2,899	1,085	2,104	1,870
85	2,225	2,595	2,930	1,097	2,129	1,892
86	2,249	2,624	2,959	1,108	2,153	1,912
87	2,273	2,651	2,992	1,120	2,176	1,933
88	2,298	2,679	3,018	1,130	2,199	1,953
89	2,320	2,703	3,044	1,139	2,219	1,972
90	2,339	2,726	3,069	1,147	2,237	1,989
91	2,359	2,749	3,094	1,157	2,257	2,006
92	2,374	2,770	3,113	1,164	2,274	2,021
93	2,392	2,791	3,134	1,171	2,291	2,037
94	2,408	2,809	3,148	1,178	2,306	2,050
95	2,421	2,826	3,166	1,184	2,319	2,062
96	2,434	2,841	3,182	1,190	2,331	2,074
97	2,449	2,858	3,199	1,195	2,347	2,088
98	2,464	2,875	3,218	1,203	2,361	2,100
99+	2,479	2,892	3,231	1,208	2,374	2,113

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: 294-295, 299

Male Rates

Attained	Preferred					
Age	Plan A	Plan B	Plan F	High F	Plan G	Plan N
65	1,482	1,726	2,048	766	1,418	1,261
66	1,482	1,726	2,048	766	1,418	1,261
67	1,482	1,726	2,048	766	1,418	1,261
68	1,543	1,799	2,134	797	1,477	1,315
69	1,613	1,880	2,217	829	1,543	1,372
70	1,677	1,955	2,298	858	1,604	1,427
71	1,740	2,028	2,377	888	1,665	1,481
72	1,802	2,099	2,452	915	1,722	1,533
73	1,859	2,167	2,517	941	1,778	1,582
74	1,912	2,228	2,583	965	1,828	1,626
75	1,960	2,284	2,640	986	1,875	1,667
76	2,004	2,338	2,693	1,006	1,918	1,706
77	2,047	2,387	2,739	1,023	1,957	1,743
78	2,087	2,433	2,781	1,039	1,996	1,778
79	2,123	2,474	2,822	1,053	2,030	1,807
80	2,158	2,514	2,856	1,067	2,064	1,836
81	2,189	2,551	2,893	1,081	2,093	1,863
82	2,219	2,585	2,929	1,094	2,121	1,888
83	2,248	2,619	2,965	1,107	2,149	1,912
84	2,276	2,650	3,000	1,119	2,176	1,936
85	2,303	2,683	3,034	1,132	2,202	1,960
86	2,327	2,711	3,062	1,143	2,226	1,981
87	2,351	2,741	3,097	1,156	2,250	2,003
88	2,376	2,769	3,124	1,166	2,274	2,024
89	2,398	2,794	3,150	1,177	2,295	2,043
90	2,419	2,818	3,178	1,187	2,314	2,060
91	2,440	2,843	3,202	1,195	2,333	2,077
92	2,458	2,864	3,222	1,204	2,350	2,092
93	2,475	2,884	3,244	1,212	2,368	2,108
94	2,492	2,904	3,258	1,217	2,384	2,121
95	2,506	2,919	3,277	1,225	2,397	2,133
96	2,519	2,935	3,293	1,230	2,410	2,145
97	2,536	2,954	3,311	1,236	2,425	2,159
98	2,550	2,971	3,329	1,243	2,438	2,172
99+	2,564	2,989	3,344	1,249	2,453	2,184

Attained	Standard					
Age	Plan A	Plan B	Plan F	High F	Plan G	Plan N
65	1,647	1,919	2,278	852	1,576	1,401
66	1,647	1,919	2,278	852	1,576	1,401
67	1,647	1,919	2,278	852	1,576	1,401
68	1,717	1,999	2,371	887	1,642	1,460
69	1,793	2,088	2,464	921	1,716	1,524
70	1,864	2,172	2,552	954	1,785	1,585
71	1,935	2,255	2,643	988	1,852	1,646
72	2,002	2,333	2,725	1,019	1,917	1,702
73	2,067	2,409	2,797	1,046	1,977	1,758
74	2,124	2,478	2,871	1,073	2,034	1,807
75	2,179	2,539	2,934	1,097	2,085	1,853
76	2,229	2,599	2,993	1,119	2,134	1,896
77	2,277	2,653	3,043	1,139	2,179	1,935
78	2,322	2,707	3,091	1,156	2,221	1,973
79	2,362	2,751	3,135	1,172	2,258	2,006
80	2,400	2,796	3,174	1,188	2,296	2,039
81	2,435	2,838	3,213	1,203	2,329	2,069
82	2,468	2,876	3,255	1,217	2,361	2,095
83	2,502	2,913	3,293	1,232	2,390	2,122
84	2,531	2,949	3,333	1,248	2,420	2,149
85	2,562	2,985	3,369	1,261	2,449	2,175
86	2,590	3,015	3,405	1,274	2,476	2,198
87	2,617	3,047	3,441	1,287	2,503	2,222
88	2,646	3,079	3,471	1,299	2,529	2,246
89	2,670	3,108	3,501	1,310	2,553	2,266
90	2,693	3,134	3,530	1,322	2,576	2,285
91	2,715	3,160	3,558	1,332	2,598	2,304
92	2,735	3,184	3,578	1,340	2,617	2,322
93	2,755	3,207	3,604	1,349	2,637	2,339
94	2,772	3,229	3,620	1,354	2,653	2,355
95	2,789	3,248	3,642	1,363	2,669	2,368
96	2,805	3,266	3,660	1,370	2,683	2,381
97	2,823	3,288	3,677	1,376	2,700	2,397
98	2,838	3,305	3,698	1,385	2,715	2,410
99+	2,855	3,324	3,716	1,390	2,732	2,424

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 Age	Preferred					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
65	1,209	1,408	1,671	624	1,156	1,029
66	1,209	1,408	1,671	624	1,156	1,029
67	1,209	1,408	1,671	624	1,156	1,029
68	1,258	1,467	1,740	651	1,205	1,072
69	1,314	1,534	1,808	676	1,258	1,119
70	1,367	1,594	1,874	701	1,309	1,165
71	1,419	1,654	1,938	725	1,357	1,209
72	1,467	1,713	2,000	748	1,405	1,251
73	1,514	1,767	2,053	768	1,450	1,292
74	1,556	1,818	2,106	788	1,491	1,328
75	1,594	1,863	2,154	806	1,529	1,361
76	1,632	1,907	2,196	822	1,564	1,393
77	1,668	1,947	2,234	836	1,597	1,422
78	1,701	1,985	2,269	849	1,629	1,449
79	1,730	2,020	2,300	860	1,656	1,475
80	1,759	2,052	2,329	871	1,683	1,499
81	1,785	2,082	2,359	882	1,708	1,521
82	1,808	2,109	2,389	893	1,731	1,542
83	1,833	2,136	2,417	904	1,752	1,561
84	1,855	2,162	2,446	914	1,774	1,581
85	1,878	2,188	2,474	924	1,796	1,600
86	1,898	2,213	2,498	934	1,815	1,617
87	1,919	2,236	2,525	944	1,834	1,635
88	1,939	2,260	2,547	952	1,853	1,651
89	1,957	2,280	2,569	960	1,870	1,667
90	1,975	2,300	2,590	969	1,887	1,681
91	1,991	2,319	2,612	976	1,903	1,694
92	2,007	2,336	2,627	983	1,917	1,707
93	2,022	2,353	2,644	990	1,930	1,719
94	2,034	2,370	2,658	994	1,943	1,730
95	2,046	2,383	2,672	999	1,954	1,740
96	2,058	2,396	2,685	1,005	1,964	1,748
97	2,071	2,413	2,700	1,009	1,977	1,759
98	2,083	2,426	2,715	1,015	1,987	1,769
99+	2,096	2,441	2,727	1,019	2,000	1,779

Attained Age	Standard					
	Plan A	Plan B	Plan F	High F	Plan G	Plan N
65	1,344	1,566	1,857	694	1,285	1,143
66	1,344	1,566	1,857	694	1,285	1,143
67	1,344	1,566	1,857	694	1,285	1,143
68	1,399	1,631	1,933	723	1,338	1,190
69	1,461	1,704	2,009	752	1,397	1,244
70	1,521	1,772	2,082	778	1,453	1,293
71	1,578	1,839	2,155	805	1,509	1,342
72	1,632	1,902	2,222	831	1,561	1,388
73	1,685	1,965	2,281	854	1,611	1,433
74	1,732	2,021	2,340	876	1,657	1,473
75	1,776	2,071	2,392	895	1,698	1,510
76	1,817	2,120	2,441	912	1,738	1,545
77	1,855	2,165	2,482	928	1,776	1,579
78	1,891	2,206	2,521	942	1,810	1,610
79	1,925	2,244	2,557	956	1,840	1,638
80	1,955	2,280	2,587	968	1,871	1,663
81	1,985	2,314	2,621	981	1,899	1,688
82	2,010	2,345	2,654	994	1,924	1,710
83	2,035	2,375	2,685	1,005	1,949	1,732
84	2,061	2,405	2,719	1,017	1,973	1,753
85	2,086	2,433	2,748	1,029	1,996	1,775
86	2,109	2,461	2,775	1,039	2,019	1,793
87	2,132	2,486	2,806	1,051	2,040	1,813
88	2,155	2,513	2,830	1,059	2,062	1,832
89	2,176	2,535	2,855	1,068	2,081	1,849
90	2,193	2,557	2,878	1,076	2,098	1,865
91	2,212	2,578	2,902	1,085	2,117	1,882
92	2,227	2,598	2,919	1,092	2,132	1,895
93	2,243	2,618	2,939	1,099	2,148	1,910
94	2,258	2,634	2,952	1,104	2,163	1,923
95	2,271	2,650	2,969	1,110	2,175	1,934
96	2,282	2,665	2,984	1,116	2,186	1,945
97	2,297	2,680	3,000	1,121	2,201	1,958
98	2,311	2,696	3,017	1,128	2,214	1,970
99+	2,325	2,712	3,030	1,133	2,227	1,982

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	1,390	1,619	1,921	718	1,330	1,183
66	1,390	1,619	1,921	718	1,330	1,183
67	1,390	1,619	1,921	718	1,330	1,183
68	1,447	1,688	2,001	748	1,385	1,233
69	1,513	1,763	2,080	777	1,447	1,287
70	1,573	1,834	2,155	805	1,504	1,339
71	1,632	1,902	2,230	833	1,561	1,389
72	1,690	1,969	2,299	858	1,615	1,438
73	1,743	2,033	2,361	882	1,667	1,484
74	1,793	2,089	2,423	905	1,714	1,525
75	1,838	2,142	2,475	925	1,758	1,563
76	1,880	2,192	2,525	944	1,798	1,600
77	1,920	2,238	2,569	959	1,836	1,635
78	1,957	2,281	2,608	974	1,872	1,667
79	1,991	2,320	2,646	988	1,904	1,694
80	2,024	2,358	2,678	1,001	1,936	1,722
81	2,053	2,392	2,713	1,013	1,963	1,747
82	2,081	2,425	2,747	1,026	1,989	1,771
83	2,108	2,456	2,780	1,038	2,015	1,793
84	2,134	2,485	2,814	1,050	2,040	1,816
85	2,160	2,516	2,845	1,061	2,065	1,838
86	2,182	2,542	2,871	1,072	2,087	1,858
87	2,205	2,571	2,905	1,084	2,110	1,879
88	2,229	2,597	2,929	1,094	2,132	1,898
89	2,249	2,621	2,954	1,103	2,152	1,916
90	2,269	2,643	2,980	1,113	2,170	1,932
91	2,288	2,667	3,003	1,121	2,188	1,948
92	2,305	2,686	3,021	1,129	2,204	1,962
93	2,321	2,705	3,042	1,137	2,221	1,977
94	2,337	2,723	3,056	1,142	2,235	1,989
95	2,350	2,737	3,073	1,149	2,248	2,000
96	2,363	2,753	3,088	1,153	2,260	2,012
97	2,378	2,770	3,105	1,159	2,275	2,025
98	2,391	2,786	3,122	1,165	2,286	2,036
99+	2,405	2,803	3,136	1,171	2,300	2,048

Attained	Standard					
Age	Plan A	Plan B	Plan F	High F	Plan G	Plan N
65	1,544	1,799	2,136	799	1,478	1,314
66	1,544	1,799	2,136	799	1,478	1,314
67	1,544	1,799	2,136	799	1,478	1,314
68	1,610	1,875	2,224	832	1,540	1,369
69	1,682	1,958	2,311	863	1,609	1,429
70	1,748	2,036	2,393	895	1,674	1,487
71	1,815	2,115	2,478	926	1,737	1,544
72	1,878	2,188	2,556	956	1,797	1,596
73	1,938	2,259	2,623	981	1,854	1,648
74	1,992	2,324	2,692	1,006	1,907	1,694
75	2,043	2,381	2,752	1,029	1,955	1,738
76	2,090	2,437	2,807	1,050	2,001	1,778
77	2,135	2,488	2,854	1,068	2,043	1,815
78	2,178	2,538	2,899	1,084	2,083	1,850
79	2,215	2,580	2,940	1,100	2,118	1,882
80	2,251	2,622	2,976	1,114	2,153	1,912
81	2,283	2,662	3,014	1,128	2,184	1,940
82	2,315	2,697	3,053	1,142	2,214	1,965
83	2,346	2,732	3,088	1,155	2,241	1,990
84	2,374	2,766	3,125	1,170	2,270	2,015
85	2,403	2,799	3,160	1,183	2,297	2,039
86	2,428	2,827	3,193	1,195	2,322	2,061
87	2,454	2,858	3,227	1,207	2,347	2,083
88	2,481	2,887	3,256	1,218	2,372	2,106
89	2,504	2,915	3,283	1,229	2,394	2,125
90	2,525	2,939	3,310	1,240	2,416	2,143
91	2,546	2,964	3,337	1,250	2,436	2,161
92	2,565	2,986	3,356	1,256	2,454	2,178
93	2,583	3,008	3,380	1,265	2,473	2,193
94	2,600	3,028	3,395	1,270	2,488	2,209
95	2,616	3,046	3,415	1,278	2,503	2,221
96	2,630	3,063	3,432	1,285	2,516	2,232
97	2,647	3,083	3,449	1,291	2,532	2,248
98	2,662	3,100	3,468	1,299	2,546	2,260
99+	2,677	3,117	3,485	1,303	2,562	2,274

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 a 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 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 $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