Aetna Health and Life Insurance Company

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Outline of Coverage

Medicare Supplement Insurance

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

Underwritten by

Aetna Health and Life Insurance Company

Georgia

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.

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		

*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 Issue Age Premiums

For Use in ZIP Codes: 300-303, 313-314

Female Rates

Issue Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	12,116	14,286	16,958	6,784	13,870	11,222
65	1,382	1,589	1,887	754	1,543	1,248
66	1,395	1,612	1,914	766	1,565	1,266
67	1,409	1,635	1,941	776	1,587	1,285
68	1,422	1,659	1,968	788	1,611	1,304
69	1,436	1,684	1,999	799	1,634	1,322
70	1,450	1,710	2,030	812	1,660	1,343
71	1,464	1,738	2,063	825	1,687	1,365
72	1,479	1,766	2,098	839	1,716	1,388
73	1,493	1,795	2,131	852	1,743	1,410
74	1,507	1,825	2,165	866	1,772	1,434
75	1,521	1,855	2,202	881	1,801	1,457
76	1,536	1,884	2,236	894	1,830	1,481
77	1,552	1,914	2,274	910	1,859	1,505
78	1,565	1,946	2,308	923	1,888	1,528
79	1,580	1,975	2,345	938	1,918	1,552
80	1,594	2,006	2,381	952	1,948	1,576
81	1,610	2,036	2,418	966	1,977	1,600
82	1,625	2,065	2,452	982	2,006	1,624
83	1,643	2,102	2,495	997	2,039	1,651
84	1,661	2,136	2,535	1,014	2,073	1,678
85	1,674	2,163	2,569	1,027	2,100	1,700
86	1,687	2,190	2,601	1,041	2,128	1,720
87	1,700	2,218	2,633	1,054	2,154	1,742
88	1,712	2,244	2,664	1,066	2,179	1,763
89	1,725	2,270	2,695	1,079	2,204	1,783
90	1,737	2,295	2,725	1,089	2,228	1,803
91	1,749	2,319	2,753	1,101	2,251	1,822
92	1,759	2,342	2,780	1,112	2,274	1,840
93	1,770	2,364	2,806	1,122	2,295	1,856
94	1,781	2,384	2,830	1,133	2,314	1,874
95	1,790	2,404	2,852	1,141	2,333	1,888
96	1,800	2,420	2,873	1,148	2,349	1,901
97	1,807	2,434	2,890	1,156	2,362	1,912
98	1,811	2,446	2,903	1,161	2,374	1,921
99	1,815	2,452	2,910	1,165	2,380	1,927

Issue Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	13,463	15,873	18,842	7,537	15,411	12,468
65	1,535	1,766	2,097	839	1,715	1,388
66	1,551	1,791	2,128	851	1,738	1,408
67	1,565	1,817	2,157	864	1,763	1,428
68	1,581	1,843	2,188	876	1,789	1,448
69	1,595	1,871	2,221	889	1,816	1,469
70	1,611	1,900	2,255	902	1,844	1,492
71	1,627	1,932	2,293	917	1,875	1,516
72	1,643	1,962	2,331	932	1,907	1,541
73	1,659	1,995	2,368	946	1,936	1,566
74	1,674	2,028	2,406	963	1,968	1,593
75	1,690	2,060	2,446	979	2,000	1,619
76	1,707	2,095	2,485	994	2,033	1,645
77	1,724	2,128	2,526	1,011	2,065	1,671
78	1,738	2,161	2,565	1,025	2,098	1,698
79	1,756	2,195	2,604	1,042	2,131	1,724
80	1,772	2,229	2,647	1,058	2,164	1,751
81	1,788	2,262	2,686	1,074	2,196	1,777
82	1,805	2,295	2,725	1,090	2,229	1,804
83	1,825	2,334	2,772	1,108	2,266	1,834
84	1,847	2,374	2,817	1,126	2,303	1,863
85	1,860	2,404	2,853	1,141	2,333	1,888
86	1,875	2,433	2,890	1,156	2,364	1,912
87	1,888	2,464	2,925	1,169	2,393	1,935
88	1,903	2,493	2,959	1,185	2,421	1,959
89	1,916	2,523	2,995	1,198	2,450	1,981
90	1,930	2,550	3,027	1,211	2,476	2,004
91	1,942	2,576	3,059	1,224	2,502	2,024
92	1,955	2,602	3,089	1,235	2,526	2,045
93	1,967	2,627	3,119	1,247	2,550	2,061
94	1,979	2,649	3,145	1,259	2,572	2,082
95	1,989	2,672	3,169	1,267	2,592	2,098
96	1,999	2,689	3,193	1,277	2,610	2,111
97	2,007	2,705	3,211	1,285	2,626	2,124
98	2,012	2,718	3,225	1,290	2,637	2,133
99	2,017	2,725	3,234	1,293	2,644	2,141

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.08330

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 Issue Age Premiums

For Use in ZIP Codes: 300-303, 313-314

Male Rates

Issue Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	13,933	16,429	19,502	7,801	15,950	12,906
65	1,588	1,828	2,170	867	1,776	1,436
66	1,605	1,854	2,202	881	1,800	1,456
67	1,620	1,881	2,233	893	1,825	1,479
68	1,635	1,908	2,263	906	1,853	1,500
69	1,652	1,936	2,299	919	1,880	1,520
70	1,667	1,966	2,334	933	1,909	1,545
71	1,684	1,999	2,373	949	1,940	1,569
72	1,700	2,032	2,412	965	1,974	1,595
73	1,717	2,064	2,451	981	2,005	1,621
74	1,732	2,099	2,491	996	2,038	1,650
75	1,750	2,133	2,532	1,014	2,071	1,676
76	1,766	2,166	2,572	1,029	2,105	1,703
77	1,784	2,202	2,615	1,045	2,137	1,730
78	1,800	2,237	2,654	1,062	2,172	1,757
79	1,816	2,272	2,696	1,080	2,205	1,784
80	1,834	2,307	2,739	1,095	2,240	1,812
81	1,851	2,340	2,780	1,112	2,273	1,840
82	1,868	2,375	2,820	1,129	2,307	1,867
83	1,889	2,417	2,869	1,147	2,346	1,899
84	1,910	2,457	2,916	1,166	2,384	1,929
85	1,926	2,487	2,954	1,181	2,414	1,955
86	1,940	2,519	2,991	1,197	2,447	1,979
87	1,955	2,551	3,028	1,212	2,477	2,004
88	1,968	2,581	3,064	1,225	2,506	2,027
89	1,984	2,610	3,099	1,240	2,535	2,051
90	1,998	2,640	3,133	1,253	2,562	2,073
91	2,011	2,667	3,166	1,266	2,590	2,096
92	2,024	2,694	3,198	1,279	2,615	2,116
93	2,036	2,719	3,227	1,291	2,640	2,135
94	2,048	2,742	3,254	1,303	2,661	2,155
95	2,059	2,765	3,279	1,312	2,682	2,172
96	2,070	2,782	3,304	1,320	2,701	2,185
97	2,078	2,800	3,323	1,330	2,718	2,198
98	2,083	2,813	3,338	1,336	2,729	2,209
99	2,087	2,820	3,346	1,339	2,736	2,215

Issue Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	15,483	18,255	21,668	8,667	17,722	14,338
65	1,765	2,032	2,411	965	1,973	1,595
66	1,783	2,060	2,447	979	1,999	1,618
67	1,800	2,090	2,480	994	2,027	1,641
68	1,817	2,120	2,517	1,008	2,058	1,665
69	1,835	2,152	2,554	1,022	2,089	1,690
70	1,853	2,184	2,594	1,037	2,122	1,716
71	1,871	2,222	2,636	1,055	2,156	1,744
72	1,889	2,257	2,680	1,071	2,194	1,774
73	1,908	2,295	2,723	1,089	2,227	1,802
74	1,926	2,333	2,767	1,108	2,263	1,833
75	1,943	2,369	2,813	1,126	2,300	1,862
76	1,964	2,408	2,858	1,142	2,338	1,892
77	1,982	2,447	2,905	1,162	2,375	1,922
78	1,999	2,485	2,950	1,180	2,412	1,953
79	2,020	2,524	2,995	1,198	2,451	1,982
80	2,038	2,563	3,043	1,217	2,489	2,013
81	2,056	2,602	3,089	1,235	2,525	2,043
82	2,077	2,640	3,133	1,254	2,563	2,074
83	2,099	2,685	3,188	1,273	2,605	2,109
84	2,124	2,729	3,239	1,294	2,649	2,144
85	2,138	2,765	3,280	1,312	2,682	2,172
86	2,156	2,799	3,323	1,330	2,719	2,198
87	2,172	2,833	3,364	1,345	2,752	2,225
88	2,188	2,867	3,403	1,362	2,784	2,253
89	2,204	2,900	3,444	1,378	2,818	2,279
90	2,221	2,932	3,480	1,392	2,847	2,305
91	2,234	2,963	3,518	1,408	2,877	2,327
92	2,249	2,992	3,552	1,421	2,905	2,352
93	2,262	3,021	3,587	1,435	2,932	2,372
94	2,276	3,047	3,617	1,447	2,957	2,394
95	2,288	3,072	3,645	1,457	2,981	2,412
96	2,299	3,093	3,672	1,468	3,002	2,428
97	2,308	3,110	3,692	1,479	3,020	2,443
98	2,314	3,125	3,709	1,483	3,033	2,453
99	2,320	3,133	3,719	1,488	3,041	2,461

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.08330

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 Issue Age Premiums

For Use in ZIP Codes: Rest of State

Female Rates

Issue Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	10,268	12,107	14,371	5,749	11,754	9,510
65	1,171	1,347	1,599	639	1,308	1,058
66	1,182	1,366	1,622	649	1,326	1,073
67	1,194	1,386	1,645	658	1,345	1,089
68	1,205	1,406	1,668	668	1,365	1,105
69	1,217	1,427	1,694	677	1,385	1,120
70	1,229	1,449	1,720	688	1,407	1,138
71	1,241	1,473	1,748	699	1,430	1,157
72	1,253	1,497	1,778	711	1,454	1,176
73	1,265	1,521	1,806	722	1,477	1,195
74	1,277	1,547	1,835	734	1,502	1,215
75	1,289	1,572	1,866	747	1,526	1,235
76	1,302	1,597	1,895	758	1,551	1,255
77	1,315	1,622	1,927	771	1,575	1,275
78	1,326	1,649	1,956	782	1,600	1,295
79	1,339	1,674	1,987	795	1,625	1,315
80	1,351	1,700	2,018	807	1,651	1,336
81	1,364	1,725	2,049	819	1,675	1,356
82	1,377	1,750	2,078	832	1,700	1,376
83	1,392	1,781	2,114	845	1,728	1,399
84	1,408	1,810	2,148	859	1,757	1,422
85	1,419	1,833	2,177	870	1,780	1,441
86	1,430	1,856	2,204	882	1,803	1,458
87	1,441	1,880	2,231	893	1,825	1,476
88	1,451	1,902	2,258	903	1,847	1,494
89	1,462	1,924	2,284	914	1,868	1,511
90	1,472	1,945	2,309	923	1,888	1,528
91	1,482	1,965	2,333	933	1,908	1,544
92	1,491	1,985	2,356	942	1,927	1,559
93	1,500	2,003	2,378	951	1,945	1,573
94	1,509	2,020	2,398	960	1,961	1,588
95	1,517	2,037	2,417	967	1,977	1,600
96	1,525	2,051	2,435	973	1,991	1,611
97	1,531	2,063	2,449	980	2,002	1,620
98	1,535	2,073	2,460	984	2,012	1,628
99	1,538	2,078	2,466	987	2,017	1,633

Issue Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	11,409	13,452	15,968	6,387	13,060	10,566
65	1,301	1,497	1,777	711	1,453	1,176
66	1,314	1,518	1,803	721	1,473	1,193
67	1,326	1,540	1,828	732	1,494	1,210
68	1,340	1,562	1,854	742	1,516	1,227
69	1,352	1,586	1,882	753	1,539	1,245
70	1,365	1,610	1,911	764	1,563	1,264
71	1,379	1,637	1,943	777	1,589	1,285
72	1,392	1,663	1,975	790	1,616	1,306
73	1,406	1,691	2,007	802	1,641	1,327
74	1,419	1,719	2,039	816	1,668	1,350
75	1,432	1,746	2,073	830	1,695	1,372
76	1,447	1,775	2,106	842	1,723	1,394
77	1,461	1,803	2,141	857	1,750	1,416
78	1,473	1,831	2,174	869	1,778	1,439
79	1,488	1,860	2,207	883	1,806	1,461
80	1,502	1,889	2,243	897	1,834	1,484
81	1,515	1,917	2,276	910	1,861	1,506
82	1,530	1,945	2,309	924	1,889	1,529
83	1,547	1,978	2,349	939	1,920	1,554
84	1,565	2,012	2,387	954	1,952	1,579
85	1,576	2,037	2,418	967	1,977	1,600
86	1,589	2,062	2,449	980	2,003	1,620
87	1,600	2,088	2,479	991	2,028	1,640
88	1,613	2,113	2,508	1,004	2,052	1,660
89	1,624	2,138	2,538	1,015	2,076	1,679
90	1,636	2,161	2,565	1,026	2,098	1,698
91	1,646	2,183	2,592	1,037	2,120	1,715
92	1,657	2,205	2,618	1,047	2,141	1,733
93	1,667	2,226	2,643	1,057	2,161	1,747
94	1,677	2,245	2,665	1,067	2,180	1,764
95	1,686	2,264	2,686	1,074	2,197	1,778
96	1,694	2,279	2,706	1,082	2,212	1,789
97	1,701	2,292	2,721	1,089	2,225	1,800
98	1,705	2,303	2,733	1,093	2,235	1,808
99	1,709	2,309	2,741	1,096	2,241	1,814

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.08330

The above rates do not include the $20 application fee

To calculate a Household discount:

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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 Issue Age Premiums

For Use in ZIP Codes: Rest of State

Male Rates

Issue Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	11,808	13,923	16,527	6,611	13,517	10,937
65	1,346	1,549	1,839	735	1,505	1,217
66	1,360	1,571	1,866	747	1,525	1,234
67	1,373	1,594	1,892	757	1,547	1,253
68	1,386	1,617	1,918	768	1,570	1,271
69	1,400	1,641	1,948	779	1,593	1,288
70	1,413	1,666	1,978	791	1,618	1,309
71	1,427	1,694	2,011	804	1,644	1,330
72	1,441	1,722	2,044	818	1,673	1,352
73	1,455	1,749	2,077	831	1,699	1,374
74	1,468	1,779	2,111	844	1,727	1,398
75	1,483	1,808	2,146	859	1,755	1,420
76	1,497	1,836	2,180	872	1,784	1,443
77	1,512	1,866	2,216	886	1,811	1,466
78	1,525	1,896	2,249	900	1,841	1,489
79	1,539	1,925	2,285	915	1,869	1,512
80	1,554	1,955	2,321	928	1,898	1,536
81	1,569	1,983	2,356	942	1,926	1,559
82	1,583	2,013	2,390	957	1,955	1,582
83	1,601	2,048	2,431	972	1,988	1,609
84	1,619	2,082	2,471	988	2,020	1,635
85	1,632	2,108	2,503	1,001	2,046	1,657
86	1,644	2,135	2,535	1,014	2,074	1,677
87	1,657	2,162	2,566	1,027	2,099	1,698
88	1,668	2,187	2,597	1,038	2,124	1,718
89	1,681	2,212	2,626	1,051	2,148	1,738
90	1,693	2,237	2,655	1,062	2,171	1,757
91	1,704	2,260	2,683	1,073	2,195	1,776
92	1,715	2,283	2,710	1,084	2,216	1,793
93	1,725	2,304	2,735	1,094	2,237	1,809
94	1,736	2,324	2,758	1,104	2,255	1,826
95	1,745	2,343	2,779	1,112	2,273	1,841
96	1,754	2,358	2,800	1,119	2,289	1,852
97	1,761	2,373	2,816	1,127	2,303	1,863
98	1,765	2,384	2,829	1,132	2,313	1,872
99	1,769	2,390	2,836	1,135	2,319	1,877

Issue Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	13,121	15,470	18,363	7,345	15,019	12,151
65	1,496	1,722	2,043	818	1,672	1,352
66	1,511	1,746	2,074	830	1,694	1,371
67	1,525	1,771	2,102	842	1,718	1,391
68	1,540	1,797	2,133	854	1,744	1,411
69	1,555	1,824	2,164	866	1,770	1,432
70	1,570	1,851	2,198	879	1,798	1,454
71	1,586	1,883	2,234	894	1,827	1,478
72	1,601	1,913	2,271	908	1,859	1,503
73	1,617	1,945	2,308	923	1,887	1,527
74	1,632	1,977	2,345	939	1,918	1,553
75	1,647	2,008	2,384	954	1,949	1,578
76	1,664	2,041	2,422	968	1,981	1,603
77	1,680	2,074	2,462	985	2,013	1,629
78	1,694	2,106	2,500	1,000	2,044	1,655
79	1,712	2,139	2,538	1,015	2,077	1,680
80	1,727	2,172	2,579	1,031	2,109	1,706
81	1,742	2,205	2,618	1,047	2,140	1,731
82	1,760	2,237	2,655	1,063	2,172	1,758
83	1,779	2,275	2,702	1,079	2,208	1,787
84	1,800	2,313	2,745	1,097	2,245	1,817
85	1,812	2,343	2,780	1,112	2,273	1,841
86	1,827	2,372	2,816	1,127	2,304	1,863
87	1,841	2,401	2,851	1,140	2,332	1,886
88	1,854	2,430	2,884	1,154	2,359	1,909
89	1,868	2,458	2,919	1,168	2,388	1,931
90	1,882	2,485	2,949	1,180	2,413	1,953
91	1,893	2,511	2,981	1,193	2,438	1,972
92	1,906	2,536	3,010	1,204	2,462	1,993
93	1,917	2,560	3,040	1,216	2,485	2,010
94	1,929	2,582	3,065	1,226	2,506	2,029
95	1,939	2,603	3,089	1,235	2,526	2,044
96	1,948	2,621	3,112	1,244	2,544	2,058
97	1,956	2,636	3,129	1,253	2,559	2,070
98	1,961	2,648	3,143	1,257	2,570	2,079
99	1,966	2,655	3,152	1,261	2,577	2,086

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.08330

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 payable other than annual 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 a 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 domestic 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 $161.00 a day	$0	Up to $161.00 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 $161.00 a day	$0	Up to $161.00 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 $161.00 a day	Up to $161.00 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 $161.00 a day	Up to $161.00 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 $161.00 a day	Up to $161.00 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 $161.00 a day	Up to $161.00 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