Outline of coverage

Medicare Supplement Insurance

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

Missouri

Underwritten by

Aetna Health and Life Insurance Company

AetnaSeniorProducts.com

AHLMS04997MO

Rates effective: 07/2023 B

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

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

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

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2024[2]					**$7,060[2]**	**$3,530[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,800** before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

Aetna Health and Life Insurance Company

Annual Premiums

Zip Codes: 630-631, 633, 640-641

Female Rates

Rates effective 7/1/2023

ISSUE AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,564	2,614	3,573	755	2,270	2,040
65	1,962	2,398	2,927	652	2,076	1,913
66	1,978	2,415	2,948	657	2,093	1,935
67	2,009	2,456	2,998	669	2,128	1,978
68	2,051	2,509	3,062	682	2,172	2,031
69	2,102	2,569	3,136	699	2,225	2,088
70	2,155	2,634	3,214	717	2,281	2,143
71	2,209	2,701	3,296	735	2,339	2,197
72	2,265	2,769	3,380	753	2,399	2,252
73	2,321	2,838	3,463	772	2,458	2,307
74	2,381	2,913	3,554	792	2,522	2,363
75	2,440	2,985	3,641	811	2,586	2,423
76	2,501	3,056	3,732	832	2,648	2,480
77	2,564	3,135	3,827	852	2,715	2,540
78	2,623	3,209	3,917	872	2,779	2,603
79	2,681	3,279	4,002	892	2,839	2,660
80	2,744	3,354	4,095	912	2,904	2,723
81	2,807	3,432	4,190	933	2,972	2,787
82	2,867	3,508	4,278	954	3,036	2,847
83	2,933	3,586	4,379	976	3,107	2,912
84	2,997	3,664	4,474	996	3,174	2,975
85	3,081	3,770	4,602	1,025	3,265	3,060
86	3,148	3,849	4,698	1,046	3,334	3,125
87	3,214	3,931	4,797	1,070	3,405	3,190
88	3,280	4,012	4,897	1,091	3,475	3,257
89	3,350	4,095	4,997	1,114	3,545	3,323
90	3,417	4,179	5,100	1,136	3,618	3,390
91	3,485	4,262	5,200	1,158	3,690	3,459
92	3,553	4,343	5,303	1,182	3,763	3,527
93	3,621	4,425	5,402	1,204	3,836	3,593
94	3,687	4,507	5,503	1,225	3,904	3,659
95	3,750	4,584	5,598	1,247	3,972	3,721
96	3,807	4,656	5,683	1,266	4,033	3,781
97	3,858	4,719	5,761	1,282	4,087	3,829
98	3,901	4,767	5,820	1,297	4,128	3,870
99+	3,922	4,796	5,855	1,305	4,154	3,893

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,849	2,904	3,970	839	2,522	2,266
65	2,180	2,662	3,251	725	2,306	2,125
66	2,197	2,685	3,277	730	2,327	2,149
67	2,233	2,731	3,332	743	2,363	2,196
68	2,279	2,789	3,403	757	2,414	2,255
69	2,336	2,854	3,487	777	2,472	2,320
70	2,396	2,928	3,573	796	2,536	2,382
71	2,454	3,000	3,662	815	2,600	2,442
72	2,516	3,077	3,756	837	2,664	2,504
73	2,577	3,152	3,848	857	2,732	2,563
74	2,647	3,237	3,948	879	2,802	2,626
75	2,712	3,317	4,048	902	2,873	2,690
76	2,779	3,397	4,146	924	2,942	2,754
77	2,849	3,484	4,252	948	3,016	2,822
78	2,915	3,565	4,351	970	3,087	2,891
79	2,980	3,643	4,446	990	3,155	2,955
80	3,049	3,727	4,549	1,014	3,228	3,025
81	3,120	3,815	4,656	1,037	3,305	3,095
82	3,188	3,896	4,757	1,061	3,376	3,162
83	3,261	3,987	4,865	1,084	3,453	3,237
84	3,331	4,071	4,971	1,107	3,527	3,305
85	3,426	4,189	5,114	1,139	3,625	3,400
86	3,498	4,276	5,220	1,163	3,705	3,472
87	3,573	4,366	5,331	1,188	3,783	3,545
88	3,646	4,460	5,441	1,212	3,862	3,618
89	3,721	4,549	5,555	1,238	3,939	3,692
90	3,797	4,641	5,667	1,261	4,019	3,765
91	3,872	4,733	5,778	1,288	4,101	3,843
92	3,947	4,828	5,892	1,313	4,181	3,919
93	4,021	4,919	6,003	1,337	4,260	3,992
94	4,096	5,008	6,115	1,362	4,338	4,064
95	4,165	5,092	6,218	1,384	4,411	4,134
96	4,230	5,173	6,316	1,407	4,482	4,200
97	4,287	5,245	6,401	1,426	4,540	4,256
98	4,332	5,298	6,466	1,440	4,588	4,299
99+	4,359	5,329	6,505	1,449	4,616	4,324

The above rates do not include the $20 application fee.

To calculate a 7% household discount:

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

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

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

Aetna Health and Life Insurance Company

Annual Premiums

Zip Codes: 630-631, 633, 640-641

Male Rates

Rates effective 7/1/2023

ISSUE AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,948	3,007	4,109	868	2,611	2,345
65	2,256	2,756	3,364	750	2,388	2,199
66	2,274	2,778	3,390	755	2,407	2,225
67	2,311	2,826	3,447	768	2,445	2,274
68	2,358	2,884	3,519	785	2,496	2,333
69	2,418	2,955	3,608	804	2,559	2,401
70	2,480	3,030	3,697	823	2,623	2,465
71	2,541	3,106	3,790	844	2,689	2,528
72	2,604	3,184	3,889	866	2,757	2,591
73	2,667	3,265	3,984	887	2,826	2,656
74	2,738	3,351	4,086	911	2,900	2,720
75	2,807	3,432	4,189	933	2,972	2,785
76	2,875	3,516	4,292	956	3,046	2,852
77	2,948	3,606	4,403	980	3,121	2,922
78	3,016	3,690	4,504	1,005	3,196	2,993
79	3,081	3,771	4,602	1,025	3,266	3,058
80	3,155	3,857	4,710	1,048	3,340	3,130
81	3,229	3,946	4,818	1,074	3,418	3,203
82	3,297	4,033	4,921	1,096	3,491	3,273
83	3,375	4,126	5,037	1,122	3,572	3,348
84	3,445	4,215	5,144	1,146	3,649	3,420
85	3,545	4,336	5,291	1,179	3,754	3,519
86	3,621	4,425	5,403	1,203	3,836	3,593
87	3,697	4,520	5,516	1,230	3,917	3,668
88	3,772	4,613	5,631	1,254	3,997	3,744
89	3,853	4,710	5,749	1,280	4,078	3,821
90	3,931	4,804	5,864	1,306	4,161	3,898
91	4,006	4,900	5,980	1,332	4,245	3,977
92	4,085	4,995	6,098	1,359	4,328	4,056
93	4,163	5,089	6,213	1,384	4,409	4,132
94	4,241	5,184	6,327	1,410	4,490	4,207
95	4,313	5,274	6,434	1,434	4,567	4,281
96	4,379	5,355	6,536	1,455	4,639	4,346
97	4,437	5,426	6,624	1,475	4,701	4,405
98	4,482	5,482	6,691	1,491	4,749	4,450
99+	4,511	5,515	6,731	1,500	4,777	4,477

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,277	3,340	4,566	964	2,902	2,605
65	2,505	3,063	3,739	833	2,654	2,443
66	2,524	3,084	3,769	840	2,675	2,473
67	2,568	3,138	3,833	855	2,718	2,527
68	2,621	3,205	3,912	870	2,775	2,594
69	2,687	3,282	4,007	894	2,845	2,668
70	2,754	3,366	4,109	916	2,916	2,740
71	2,822	3,451	4,213	937	2,989	2,808
72	2,895	3,539	4,321	962	3,065	2,878
73	2,966	3,625	4,424	986	3,142	2,947
74	3,044	3,722	4,543	1,012	3,222	3,023
75	3,119	3,815	4,655	1,036	3,305	3,095
76	3,196	3,905	4,771	1,063	3,384	3,170
77	3,277	4,005	4,889	1,089	3,469	3,247
78	3,353	4,099	5,003	1,116	3,549	3,324
79	3,427	4,192	5,114	1,139	3,630	3,399
80	3,504	4,286	5,232	1,165	3,713	3,478
81	3,586	4,386	5,355	1,193	3,799	3,558
82	3,664	4,480	5,470	1,219	3,880	3,637
83	3,750	4,584	5,594	1,247	3,970	3,721
84	3,830	4,684	5,716	1,272	4,056	3,800
85	3,937	4,817	5,881	1,310	4,172	3,910
86	4,021	4,919	6,003	1,337	4,259	3,992
87	4,109	5,022	6,130	1,366	4,351	4,077
88	4,193	5,126	6,257	1,393	4,440	4,161
89	4,278	5,232	6,388	1,422	4,530	4,246
90	4,366	5,339	6,515	1,450	4,622	4,332
91	4,453	5,443	6,644	1,481	4,717	4,418
92	4,542	5,551	6,774	1,509	4,810	4,506
93	4,626	5,656	6,904	1,539	4,900	4,591
94	4,711	5,760	7,032	1,566	4,990	4,675
95	4,789	5,858	7,150	1,593	5,074	4,753
96	4,865	5,951	7,262	1,617	5,154	4,829
97	4,929	6,031	7,361	1,640	5,223	4,894
98	4,982	6,093	7,436	1,656	5,276	4,945
99+	5,013	6,128	7,482	1,667	5,308	4,974

The above rates do not include the $20 application fee.

To calculate a 7% household discount:

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

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

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

Aetna Health and Life Insurance Company

Annual Premiums

Zip Codes: Rest of State

Female Rates

Rates effective 7/1/2023

ISSUE AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,289	2,334	3,190	674	2,027	1,821
65	1,752	2,141	2,613	582	1,854	1,708
66	1,766	2,156	2,632	587	1,869	1,728
67	1,794	2,193	2,677	597	1,900	1,766
68	1,831	2,240	2,734	609	1,939	1,813
69	1,877	2,294	2,800	624	1,987	1,864
70	1,924	2,352	2,870	640	2,037	1,913
71	1,972	2,412	2,943	656	2,088	1,962
72	2,022	2,472	3,018	672	2,142	2,011
73	2,072	2,534	3,092	689	2,195	2,060
74	2,126	2,601	3,173	707	2,252	2,110
75	2,179	2,665	3,251	724	2,309	2,163
76	2,233	2,729	3,332	743	2,364	2,214
77	2,289	2,799	3,417	761	2,424	2,268
78	2,342	2,865	3,497	779	2,481	2,324
79	2,394	2,928	3,573	796	2,535	2,375
80	2,450	2,995	3,656	814	2,593	2,431
81	2,506	3,064	3,741	833	2,654	2,488
82	2,560	3,132	3,820	852	2,711	2,542
83	2,619	3,202	3,910	871	2,774	2,600
84	2,676	3,271	3,995	889	2,834	2,656
85	2,751	3,366	4,109	915	2,915	2,732
86	2,811	3,437	4,195	934	2,977	2,790
87	2,870	3,510	4,283	955	3,040	2,848
88	2,929	3,582	4,372	974	3,103	2,908
89	2,991	3,656	4,462	995	3,165	2,967
90	3,051	3,731	4,554	1,014	3,230	3,027
91	3,112	3,805	4,643	1,034	3,295	3,088
92	3,172	3,878	4,735	1,055	3,360	3,149
93	3,233	3,951	4,823	1,075	3,425	3,208
94	3,292	4,024	4,913	1,094	3,486	3,267
95	3,348	4,093	4,998	1,113	3,546	3,322
96	3,399	4,157	5,074	1,130	3,601	3,376
97	3,445	4,213	5,144	1,145	3,649	3,419
98	3,483	4,256	5,196	1,158	3,686	3,455
99+	3,502	4,282	5,228	1,165	3,709	3,476

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,544	2,593	3,545	749	2,252	2,023
65	1,946	2,377	2,903	647	2,059	1,897
66	1,962	2,397	2,926	652	2,078	1,919
67	1,994	2,438	2,975	663	2,110	1,961
68	2,035	2,490	3,038	676	2,155	2,013
69	2,086	2,548	3,113	694	2,207	2,071
70	2,139	2,614	3,190	711	2,264	2,127
71	2,191	2,679	3,270	728	2,321	2,180
72	2,246	2,747	3,354	747	2,379	2,236
73	2,301	2,814	3,436	765	2,439	2,288
74	2,363	2,890	3,525	785	2,502	2,345
75	2,421	2,962	3,614	805	2,565	2,402
76	2,481	3,033	3,702	825	2,627	2,459
77	2,544	3,111	3,796	846	2,693	2,520
78	2,603	3,183	3,885	866	2,756	2,581
79	2,661	3,253	3,970	884	2,817	2,638
80	2,722	3,328	4,062	905	2,882	2,701
81	2,786	3,406	4,157	926	2,951	2,763
82	2,846	3,479	4,247	947	3,014	2,823
83	2,912	3,560	4,344	968	3,083	2,890
84	2,974	3,635	4,438	988	3,149	2,951
85	3,059	3,740	4,566	1,017	3,237	3,036
86	3,123	3,818	4,661	1,038	3,308	3,100
87	3,190	3,898	4,760	1,061	3,378	3,165
88	3,255	3,982	4,858	1,082	3,448	3,230
89	3,322	4,062	4,960	1,105	3,517	3,296
90	3,390	4,144	5,060	1,126	3,588	3,362
91	3,457	4,226	5,159	1,150	3,662	3,431
92	3,524	4,311	5,261	1,172	3,733	3,499
93	3,590	4,392	5,360	1,194	3,804	3,564
94	3,657	4,471	5,460	1,216	3,873	3,629
95	3,719	4,546	5,552	1,236	3,938	3,691
96	3,777	4,619	5,639	1,256	4,002	3,750
97	3,828	4,683	5,715	1,273	4,054	3,800
98	3,868	4,730	5,773	1,286	4,096	3,838
99+	3,892	4,758	5,808	1,294	4,121	3,861

The above rates do not include the $20 application fee.

To calculate a 7% household discount:

Annual premium **x** modal factor**= modal premium** (round to nearest whole cent)

Modal premium **x** discount (.93)**= discounted premium**

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

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

Aetna Health and Life Insurance Company

Annual Premiums

Zip Codes: Rest of State

Male Rates

Rates effective 7/1/2023

ISSUE AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,632	2,685	3,669	775	2,331	2,094
65	2,014	2,461	3,004	670	2,132	1,963
66	2,030	2,480	3,027	674	2,149	1,987
67	2,063	2,523	3,078	686	2,183	2,030
68	2,105	2,575	3,142	701	2,229	2,083
69	2,159	2,638	3,221	718	2,285	2,144
70	2,214	2,705	3,301	735	2,342	2,201
71	2,269	2,773	3,384	754	2,401	2,257
72	2,325	2,843	3,472	773	2,462	2,313
73	2,381	2,915	3,557	792	2,523	2,371
74	2,445	2,992	3,648	813	2,589	2,429
75	2,506	3,064	3,740	833	2,654	2,487
76	2,567	3,139	3,832	854	2,720	2,546
77	2,632	3,220	3,931	875	2,787	2,609
78	2,693	3,295	4,021	897	2,854	2,672
79	2,751	3,367	4,109	915	2,916	2,730
80	2,817	3,444	4,205	936	2,982	2,795
81	2,883	3,523	4,302	959	3,052	2,860
82	2,944	3,601	4,394	979	3,117	2,922
83	3,013	3,684	4,497	1,002	3,189	2,989
84	3,076	3,763	4,593	1,023	3,258	3,054
85	3,165	3,871	4,724	1,053	3,352	3,142
86	3,233	3,951	4,824	1,074	3,425	3,208
87	3,301	4,036	4,925	1,098	3,497	3,275
88	3,368	4,119	5,028	1,120	3,569	3,343
89	3,440	4,205	5,133	1,143	3,641	3,412
90	3,510	4,289	5,236	1,166	3,715	3,480
91	3,577	4,375	5,339	1,189	3,790	3,551
92	3,647	4,460	5,445	1,213	3,864	3,621
93	3,717	4,544	5,547	1,236	3,937	3,689
94	3,787	4,629	5,649	1,259	4,009	3,756
95	3,851	4,709	5,745	1,280	4,078	3,822
96	3,910	4,781	5,836	1,299	4,142	3,880
97	3,962	4,845	5,914	1,317	4,197	3,933
98	4,002	4,895	5,974	1,331	4,240	3,973
99+	4,028	4,924	6,010	1,339	4,265	3,997

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,926	2,982	4,077	861	2,591	2,326
65	2,237	2,735	3,338	744	2,370	2,181
66	2,254	2,754	3,365	750	2,388	2,208
67	2,293	2,802	3,422	763	2,427	2,256
68	2,340	2,862	3,493	777	2,478	2,316
69	2,399	2,930	3,578	798	2,540	2,382
70	2,459	3,005	3,669	818	2,604	2,446
71	2,520	3,081	3,762	837	2,669	2,507
72	2,585	3,160	3,858	859	2,737	2,570
73	2,648	3,237	3,950	880	2,805	2,631
74	2,718	3,323	4,056	904	2,877	2,699
75	2,785	3,406	4,156	925	2,951	2,763
76	2,854	3,487	4,260	949	3,021	2,830
77	2,926	3,576	4,365	972	3,097	2,899
78	2,994	3,660	4,467	996	3,169	2,968
79	3,060	3,743	4,566	1,017	3,241	3,035
80	3,129	3,827	4,671	1,040	3,315	3,105
81	3,202	3,916	4,781	1,065	3,392	3,177
82	3,271	4,000	4,884	1,088	3,464	3,247
83	3,348	4,093	4,995	1,113	3,545	3,322
84	3,420	4,182	5,104	1,136	3,621	3,393
85	3,515	4,301	5,251	1,170	3,725	3,491
86	3,590	4,392	5,360	1,194	3,803	3,564
87	3,669	4,484	5,473	1,220	3,885	3,640
88	3,744	4,577	5,587	1,244	3,964	3,715
89	3,820	4,671	5,704	1,270	4,045	3,791
90	3,898	4,767	5,817	1,295	4,127	3,868
91	3,976	4,860	5,932	1,322	4,212	3,945
92	4,055	4,956	6,048	1,347	4,295	4,023
93	4,130	5,050	6,164	1,374	4,375	4,099
94	4,206	5,143	6,279	1,398	4,455	4,174
95	4,276	5,230	6,384	1,422	4,530	4,244
96	4,344	5,313	6,484	1,444	4,602	4,312
97	4,401	5,385	6,572	1,464	4,663	4,370
98	4,448	5,440	6,639	1,479	4,711	4,415
99+	4,476	5,471	6,680	1,488	4,739	4,441

The above rates do not include the $20 application fee.

To calculate a 7% household discount:

Annual premium **x** modal factor**= modal premium** (round to nearest whole cent)

Modal premium **x** discount (.93)**= discounted premium**

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

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

PREMIUM INFORMATION

Aetna Health and Life Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state. Premiums may be changed for this policy on any premium due date, provided premiums for all policies issued on this form number in your state are also changed. For every nonscheduled premium change, we will give you at least 30 days advance notice in writing of such premium change. 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 company Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; or (b) be someone with whom you are in a civil union partnership; and (c) someone with whom you have continuously resided for the past 12 months. The household discount will only be applicable if a policy for each applicant is issued. The discounted rate will be 7 percent lower than the individual rates and will apply as long as both policies remain in force.

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

The policy may not cover all of your medical costs. Neither Aetna Health 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 BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$0	$1,632 (Part A Deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

HIGH DEDUCTIBLE PLAN F

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

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

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – **NOT COVERED BY MEDICARE** Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum