

**Aetna Life Insurance Company
Outline of Medicare Supplement Coverage**

Benefit Plans A, B and F are Offered

This chart shows the benefits included in each of the standard Medicare supplement plans. Every insurer must make available Plan "A" and "B," and either "C" or "F." Some plans may not be available in your state. **Plans "E," "H," "I" and "J" are no longer available for sale.**

Basic Benefits:

- **Hospitalization** - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** - Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insured to pay a portion of Part B coinsurance or copayments.
- **Blood** - First three pints of blood each year.
- **Hospice** - Part A coinsurance.

A	B	C	D	F I 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 \$4,660; paid at 100% after limit reached	Out-of-pocket limit \$2,330; paid at 100% after limit reached		

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* Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year \$2,070 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2,070. 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.

PREMIUM INFORMATION

Questions? We're here to help.

Just call us at 1-800-345-6022
(TTY/TDD 1-800-628-3323)

We, Aetna Life Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this state or to coincide with changes in Medicare. Aetna will send a written notice at least 60 days before the change becomes effective.

MONTHLY PREMIUMS

The following rates apply to these zip codes:

Zip Codes	Plan A	Plan B	Plan F
00500 - 00599; 06300 - 06399; 10000 - 11999	\$242.58	\$293.77	\$343.02

Zip Codes	Plan A	Plan B	Plan F
12400 - 12799	\$201.34	\$243.83	\$284.72

Zip Codes	Plan A	Plan B	Plan F
12000 - 12399; 12800 - 12899; 12900 - 12999	\$181.93	\$220.34	\$257.26

Zip Codes	Plan A	Plan B	Plan F
13200 - 13299; 13500 - 13599; 13600 - 13699; 14000 - 14399; 14600 - 14699	\$174.66	\$211.52	\$246.98

Zip Codes	Plan A	Plan B	Plan F
13000 - 13099; 13100 - 13199; 13300 - 13399; 13400 - 13499; 13700 - 13999; 14400 - 14499; 14500 - 14599; 14700 - 14999	\$157.68	\$190.95	\$222.97

The monthly premiums shown will apply when payment is made on a quarterly, semi-annual or annual basis or if you elect to have your payments automatically deducted from your checking account (Electronic Funds Transfer program) or credit card account. To obtain quarterly premium, multiply the monthly premium by 3. For semi-annual premium and annual premium, multiply the monthly premium by 6 or 12, respectively. If you elect to pay your premium on a monthly basis by check or money order, add \$2 to the monthly premium shown to calculate your monthly premium amount

DISCLOSURES

Questions? We're here to help.

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Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after January 1, 2012. Policies sold for effective dates prior to January 1, 2012 have different benefits and premiums. Plans E, H, I and J are no longer available for sale.

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 Aetna Life Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Aetna Life Insurance Company, PO Box 13547, Pensacola, FL, 32591. 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 of 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

This policy may not fully cover all of your medical costs. Neither Aetna 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

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

PLAN A
Medicare (Part A) – Hospital Services – Per Benefit Period

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,156	\$0	\$1,156 (Part A deductible)
61st thru 90th day	All but \$289 a day	\$289 a day	\$0
91st day and after:			
▪ While using 60 lifetime reserve days	All but \$578 a day	\$578 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 \$144.50 a day	\$0	Up to \$144.50 a day
101st day and after	\$0	\$0	All costs

*A **Benefit Period** begins on the first day you receive care 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.

PLAN A (continued)
Medicare (Part A) – Hospital Services – Per Benefit Period

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 a very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

PLAN A
Medicare (Part B) – Medical Services – Per Calendar Year

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENTS , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$140 of Medicare-approved amounts*	\$0	\$0	\$140 (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

*Once you have been billed \$140 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.

PLAN A (continued)
Medicare (Part B) – Medical Services – Per Calendar Year

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$140 of Medicare-approved amounts*	\$0	\$0	\$140 (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 \$140 of Medicare-approved amounts*	\$0	\$0	\$140 (Part B deductible)
- Remainder of Medicare-approved amounts	80%	20%	\$0

*Once you have been billed \$140 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.

PLAN B
Medicare (Part A) – Hospital Services – Per Benefit Period

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,156	\$1,156 (Part A deductible)	\$0
61 st thru 90 th day	All but \$289 a day	\$289 a day	\$0
91 st day and after:			
▪ While using 60 lifetime reserve days	All but \$578 a day	\$578 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
21 st thru 100 th day	All but \$144.50 a day	\$0	Up to \$144.50 a day
101 st day and after	\$0	\$0	All costs

*A **Benefit Period** begins on the first day you receive care 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.

PLAN B (continued)
Medicare (Part A) – Hospital Services – Per Benefit Period

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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

PLAN B
Medicare (Part B) – Medical Services – Per Calendar Year

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENTS , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$140 of Medicare-approved amounts*	\$0	\$0	\$140 (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

*Once you have been billed \$140 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.

PLAN B (continued)
Medicare (Part B) – Medical Services – Per Calendar Year

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$140 of Medicare-approved amounts*	\$0	\$0	\$140 (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 \$140 of Medicare-approved amounts*	\$0	\$0	\$140 (Part B deductible)
- Remainder of Medicare-approved amounts	80%	20%	\$0

*Once you have been billed \$140 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.

PLAN F
Medicare (Part A) – Hospital Services – Per Benefit Period

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,156	\$1,156 (Part A deductible)	\$0
61st thru 90th day	All but \$289 a day	\$289 a day	\$0
91st day and after:			
▪ While using 60 lifetime reserve days	All but \$578 a day	\$578 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 \$144.50 a day	Up to \$144.50 a day	\$0
101st day and after	\$0	\$0	All costs

*A **Benefit Period** begins on the first day you receive care 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.

PLAN F (continued)
Medicare (Part A) – Hospital Services – Per Benefit Period

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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

PLAN F
Medicare (Part B) – Medical Services – Per Calendar Year

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES			
IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENTS , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$140 of Medicare-approved amounts*	\$0	\$140 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare-approved amounts)	\$0	100% of all costs	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$140 of Medicare-approved amounts*	\$0	\$140 (Part B deductible)	\$0
Remainder of Medicare-approved amounts	80%	20%	\$0

*Once you have been billed \$140 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.

PLAN F (continued)
Medicare (Part B) – Medical Services – Per Calendar Year

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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 \$140 of Medicare-approved amounts*	\$0	\$140 (Part B deductible)	\$0
- 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 such charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

*Once you have been billed \$140 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.