Medicare Supplement Insurance Office
800 Crescent Centre Dr.
Suite 200
Franklin, TN 37067
855 663.2201
aetnaseniorproducts.com

Outline of Coverage

Medicare Supplement Insurance

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

Insured by

An Aetna Company **Aetna Health Insurance Company**

Ohio

AHCMS03883OH

Rates Effective: 05/2018 A

AETNA HEALTH 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 co-payments
- 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 co-payment for office visit, and up to $50 co-payment 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 $5240; paid at 100% after limit reached	Out-of-pocket limit $2620; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2240 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2240. 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 Insurance Company

Annual Premiums

For Use in ZIP Codes: 450-454 and 459

Female Rates

Rates Effective 5/1/2018

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,157	1,224	1,571	628	1,321	972
66	1,157	1,224	1,571	628	1,321	1,000
67	1,157	1,224	1,571	628	1,321	1,026
68	1,172	1,239	1,590	636	1,337	1,067
69	1,197	1,265	1,623	650	1,366	1,117
70	1,229	1,299	1,666	667	1,402	1,175
71	1,265	1,338	1,717	687	1,444	1,210
72	1,304	1,380	1,770	708	1,489	1,247
73	1,347	1,425	1,828	731	1,537	1,287
74	1,394	1,475	1,892	757	1,592	1,334
75	1,445	1,529	1,961	784	1,650	1,383
76	1,496	1,582	2,030	812	1,707	1,430
77	1,547	1,636	2,099	839	1,765	1,479
78	1,597	1,688	2,167	866	1,823	1,527
79	1,649	1,744	2,238	895	1,882	1,577
80	1,701	1,799	2,308	923	1,941	1,626
81	1,755	1,855	2,380	952	2,002	1,678
82	1,809	1,913	2,455	982	2,065	1,730
83	1,865	1,972	2,531	1,012	2,128	1,783
84	1,922	2,033	2,608	1,044	2,193	1,838
85	1,989	2,103	2,700	1,079	2,270	1,902
86	2,045	2,164	2,776	1,111	2,335	1,956
87	2,104	2,225	2,855	1,142	2,401	2,012
88	2,163	2,288	2,935	1,174	2,469	2,069
89	2,223	2,351	3,017	1,206	2,538	2,125
90	2,284	2,416	3,100	1,240	2,607	2,184
91	2,346	2,481	3,184	1,274	2,679	2,243
92	2,410	2,548	3,270	1,308	2,750	2,304
93	2,474	2,617	3,357	1,343	2,823	2,366
94	2,539	2,685	3,446	1,379	2,898	2,428
95	2,605	2,755	3,535	1,414	2,974	2,491
96	2,672	2,827	3,627	1,451	3,050	2,556
97	2,741	2,899	3,719	1,488	3,129	2,621
98	2,810	2,973	3,814	1,526	3,208	2,688
99+	2,880	3,046	3,909	1,563	3,288	2,754

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,285	1,361	1,745	697	1,468	1,080
66	1,285	1,361	1,745	697	1,468	1,110
67	1,285	1,361	1,745	697	1,468	1,140
68	1,302	1,377	1,766	707	1,485	1,185
69	1,330	1,406	1,804	722	1,518	1,241
70	1,365	1,443	1,851	741	1,557	1,305
71	1,406	1,487	1,908	763	1,604	1,344
72	1,449	1,533	1,967	786	1,655	1,387
73	1,497	1,583	2,031	812	1,708	1,431
74	1,550	1,639	2,102	841	1,768	1,482
75	1,605	1,699	2,180	872	1,833	1,535
76	1,662	1,758	2,255	902	1,897	1,589
77	1,719	1,818	2,332	932	1,961	1,643
78	1,775	1,876	2,408	963	2,025	1,697
79	1,831	1,938	2,486	994	2,091	1,751
80	1,890	1,998	2,564	1,026	2,157	1,807
81	1,950	2,061	2,645	1,058	2,225	1,865
82	2,010	2,125	2,728	1,091	2,295	1,923
83	2,072	2,191	2,812	1,125	2,365	1,981
84	2,135	2,259	2,898	1,159	2,437	2,042
85	2,209	2,337	3,000	1,199	2,522	2,113
86	2,272	2,405	3,085	1,235	2,595	2,174
87	2,338	2,472	3,172	1,269	2,668	2,235
88	2,403	2,542	3,261	1,304	2,743	2,297
89	2,470	2,612	3,352	1,341	2,820	2,361
90	2,538	2,685	3,444	1,378	2,897	2,427
91	2,606	2,757	3,537	1,415	2,976	2,492
92	2,678	2,832	3,633	1,453	3,056	2,560
93	2,749	2,907	3,730	1,492	3,137	2,629
94	2,821	2,983	3,829	1,532	3,220	2,697
95	2,895	3,062	3,928	1,572	3,304	2,768
96	2,969	3,141	4,030	1,613	3,389	2,839
97	3,045	3,221	4,133	1,653	3,477	2,913
98	3,122	3,303	4,238	1,695	3,564	2,986
99+	3,200	3,384	4,344	1,737	3,653	3,061

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

The above rates do not include the $20 one-time policy 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 Insurance Company

Annual Premiums
For Use in ZIP Codes: 450-454 and 459
Male Rates

Rates Effective 5/1/2018

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,330	1,408	1,806	722	1,519	1,119
66	1,330	1,408	1,806	722	1,519	1,150
67	1,330	1,408	1,806	722	1,519	1,180
68	1,347	1,425	1,828	732	1,537	1,226
69	1,377	1,455	1,867	748	1,571	1,284
70	1,413	1,494	1,916	767	1,612	1,351
71	1,455	1,538	1,974	790	1,660	1,391
72	1,499	1,587	2,036	814	1,713	1,434
73	1,549	1,639	2,102	840	1,768	1,482
74	1,603	1,697	2,176	870	1,830	1,533
75	1,661	1,758	2,255	902	1,897	1,590
76	1,721	1,820	2,334	933	1,964	1,644
77	1,779	1,882	2,414	965	2,030	1,701
78	1,836	1,941	2,493	996	2,096	1,757
79	1,896	2,006	2,574	1,029	2,164	1,813
80	1,956	2,069	2,654	1,062	2,232	1,871
81	2,018	2,134	2,737	1,095	2,303	1,930
82	2,080	2,200	2,823	1,129	2,375	1,990
83	2,144	2,268	2,911	1,164	2,448	2,051
84	2,210	2,337	3,000	1,200	2,522	2,114
85	2,287	2,418	3,105	1,241	2,610	2,187
86	2,352	2,489	3,193	1,278	2,686	2,249
87	2,420	2,559	3,283	1,314	2,762	2,314
88	2,487	2,631	3,375	1,350	2,839	2,378
89	2,557	2,704	3,469	1,387	2,919	2,444
90	2,626	2,778	3,565	1,426	2,998	2,513
91	2,697	2,853	3,661	1,465	3,081	2,580
92	2,771	2,931	3,760	1,505	3,163	2,649
93	2,844	3,009	3,861	1,545	3,247	2,722
94	2,920	3,088	3,963	1,586	3,333	2,792
95	2,996	3,169	4,066	1,626	3,420	2,864
96	3,073	3,251	4,171	1,668	3,508	2,940
97	3,152	3,334	4,277	1,712	3,598	3,015
98	3,231	3,419	4,386	1,755	3,689	3,091
99+	3,312	3,503	4,495	1,798	3,781	3,167

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,478	1,565	2,007	802	1,688	1,243
66	1,478	1,565	2,007	802	1,688	1,277
67	1,478	1,565	2,007	802	1,688	1,311
68	1,497	1,583	2,031	813	1,707	1,363
69	1,530	1,617	2,075	831	1,746	1,427
70	1,570	1,659	2,128	853	1,790	1,500
71	1,617	1,709	2,195	878	1,845	1,547
72	1,666	1,763	2,262	904	1,903	1,594
73	1,722	1,821	2,335	933	1,965	1,646
74	1,782	1,885	2,417	967	2,034	1,703
75	1,846	1,954	2,506	1,003	2,108	1,766
76	1,911	2,021	2,594	1,037	2,182	1,827
77	1,977	2,091	2,682	1,072	2,255	1,890
78	2,041	2,158	2,769	1,108	2,329	1,951
79	2,106	2,229	2,859	1,143	2,405	2,015
80	2,174	2,297	2,948	1,180	2,480	2,078
81	2,243	2,370	3,042	1,217	2,559	2,144
82	2,311	2,444	3,137	1,255	2,640	2,210
83	2,382	2,520	3,234	1,294	2,720	2,277
84	2,455	2,598	3,333	1,334	2,802	2,349
85	2,541	2,688	3,450	1,379	2,900	2,430
86	2,613	2,766	3,548	1,420	2,984	2,500
87	2,689	2,842	3,648	1,460	3,068	2,571
88	2,764	2,923	3,751	1,499	3,154	2,642
89	2,840	3,004	3,855	1,542	3,243	2,715
90	2,919	3,088	3,961	1,584	3,332	2,791
91	2,997	3,171	4,068	1,628	3,422	2,865
92	3,080	3,257	4,178	1,672	3,514	2,944
93	3,162	3,343	4,289	1,716	3,608	3,023
94	3,245	3,430	4,404	1,762	3,703	3,102
95	3,330	3,521	4,517	1,808	3,800	3,184
96	3,415	3,612	4,635	1,854	3,898	3,266
97	3,502	3,704	4,752	1,901	3,998	3,350
98	3,590	3,799	4,873	1,949	4,098	3,435
99+	3,680	3,891	4,996	1,997	4,201	3,519

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

The above rates do not include the $20 one-time policy 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 Insurance Company

Annual Premiums

For Use in ZIP Codes: 436 and 440-445

Female Rates

Rates Effective 5/1/2018

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,289	1,364	1,750	700	1,472	1,083
66	1,289	1,364	1,750	700	1,472	1,114
67	1,289	1,364	1,750	700	1,472	1,143
68	1,306	1,381	1,771	709	1,489	1,189
69	1,334	1,410	1,809	724	1,522	1,245
70	1,369	1,447	1,857	743	1,562	1,309
71	1,410	1,491	1,913	765	1,609	1,348
72	1,453	1,537	1,973	789	1,659	1,390
73	1,501	1,588	2,037	814	1,713	1,434
74	1,554	1,644	2,108	844	1,774	1,486
75	1,610	1,704	2,186	874	1,838	1,541
76	1,667	1,763	2,262	904	1,902	1,594
77	1,723	1,823	2,339	935	1,967	1,649
78	1,780	1,881	2,415	965	2,031	1,701
79	1,837	1,943	2,493	997	2,097	1,757
80	1,895	2,004	2,572	1,028	2,163	1,812
81	1,955	2,067	2,652	1,061	2,231	1,870
82	2,016	2,132	2,735	1,094	2,301	1,928
83	2,078	2,197	2,820	1,128	2,372	1,987
84	2,141	2,265	2,906	1,163	2,444	2,048
85	2,216	2,344	3,008	1,203	2,530	2,119
86	2,279	2,411	3,093	1,238	2,602	2,180
87	2,345	2,479	3,181	1,273	2,676	2,242
88	2,410	2,549	3,270	1,308	2,751	2,305
89	2,477	2,620	3,361	1,344	2,828	2,368
90	2,545	2,692	3,454	1,382	2,905	2,434
91	2,614	2,765	3,547	1,419	2,985	2,499
92	2,685	2,840	3,643	1,458	3,064	2,567
93	2,757	2,916	3,740	1,496	3,146	2,636
94	2,829	2,992	3,840	1,536	3,229	2,705
95	2,903	3,070	3,939	1,576	3,313	2,775
96	2,978	3,150	4,041	1,617	3,399	2,848
97	3,054	3,230	4,144	1,658	3,487	2,920
98	3,131	3,312	4,249	1,700	3,574	2,995
99+	3,209	3,394	4,356	1,742	3,663	3,069

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,432	1,516	1,945	777	1,636	1,204
66	1,432	1,516	1,945	777	1,636	1,237
67	1,432	1,516	1,945	777	1,636	1,271
68	1,451	1,534	1,968	787	1,654	1,321
69	1,482	1,567	2,010	805	1,692	1,383
70	1,521	1,608	2,063	826	1,735	1,454
71	1,567	1,657	2,126	851	1,788	1,498
72	1,615	1,708	2,191	876	1,844	1,546
73	1,668	1,764	2,263	904	1,904	1,595
74	1,727	1,826	2,342	937	1,970	1,651
75	1,789	1,893	2,429	971	2,043	1,711
76	1,852	1,959	2,513	1,005	2,114	1,770
77	1,915	2,025	2,599	1,039	2,186	1,831
78	1,977	2,091	2,683	1,073	2,257	1,891
79	2,040	2,160	2,771	1,108	2,329	1,952
80	2,106	2,227	2,857	1,143	2,403	2,014
81	2,173	2,297	2,947	1,179	2,479	2,078
82	2,239	2,368	3,040	1,216	2,558	2,142
83	2,308	2,442	3,133	1,253	2,635	2,208
84	2,379	2,517	3,229	1,292	2,716	2,276
85	2,462	2,604	3,343	1,336	2,810	2,354
86	2,532	2,679	3,437	1,376	2,891	2,422
87	2,606	2,754	3,535	1,415	2,973	2,491
88	2,678	2,833	3,634	1,453	3,056	2,560
89	2,752	2,911	3,735	1,494	3,143	2,631
90	2,828	2,992	3,838	1,535	3,228	2,704
91	2,904	3,072	3,942	1,577	3,316	2,776
92	2,984	3,155	4,048	1,619	3,405	2,852
93	3,063	3,240	4,156	1,663	3,496	2,930
94	3,144	3,324	4,267	1,707	3,588	3,006
95	3,226	3,412	4,377	1,751	3,682	3,084
96	3,309	3,499	4,490	1,797	3,777	3,164
97	3,393	3,590	4,605	1,842	3,874	3,246
98	3,478	3,681	4,722	1,888	3,971	3,327
99+	3,566	3,771	4,840	1,935	4,070	3,411

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

The above rates do not include the $20 one-time policy 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 Insurance Company

Annual Premiums

For Use in ZIP Codes: 436 and 440-445

Male Rates

Rates Effective 5/1/2018

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,482	1,569	2,012	805	1,693	1,247
66	1,482	1,569	2,012	805	1,693	1,281
67	1,482	1,569	2,012	805	1,693	1,315
68	1,501	1,588	2,037	815	1,713	1,367
69	1,534	1,622	2,080	833	1,750	1,431
70	1,575	1,665	2,135	854	1,796	1,506
71	1,622	1,714	2,200	880	1,850	1,550
72	1,671	1,768	2,269	907	1,908	1,598
73	1,726	1,826	2,342	936	1,970	1,651
74	1,787	1,891	2,424	970	2,039	1,708
75	1,851	1,959	2,513	1,005	2,114	1,771
76	1,918	2,028	2,601	1,040	2,188	1,832
77	1,982	2,097	2,690	1,075	2,262	1,895
78	2,046	2,163	2,778	1,110	2,335	1,957
79	2,113	2,235	2,868	1,147	2,411	2,021
80	2,180	2,305	2,958	1,183	2,487	2,085
81	2,249	2,377	3,050	1,220	2,566	2,150
82	2,318	2,451	3,146	1,258	2,647	2,217
83	2,389	2,527	3,243	1,298	2,727	2,285
84	2,463	2,604	3,343	1,337	2,810	2,355
85	2,548	2,695	3,460	1,383	2,909	2,437
86	2,621	2,773	3,558	1,424	2,993	2,506
87	2,697	2,851	3,659	1,464	3,077	2,579
88	2,772	2,932	3,760	1,505	3,164	2,650
89	2,849	3,013	3,866	1,546	3,253	2,724
90	2,926	3,096	3,972	1,589	3,340	2,800
91	3,006	3,179	4,080	1,632	3,433	2,875
92	3,088	3,265	4,190	1,677	3,524	2,952
93	3,170	3,353	4,302	1,721	3,618	3,033
94	3,254	3,441	4,416	1,767	3,714	3,111
95	3,338	3,531	4,530	1,812	3,811	3,192
96	3,425	3,622	4,647	1,859	3,909	3,276
97	3,512	3,715	4,765	1,907	4,010	3,359
98	3,600	3,810	4,887	1,955	4,110	3,444
99+	3,690	3,903	5,009	2,003	4,213	3,529

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,647	1,743	2,236	894	1,881	1,385
66	1,647	1,743	2,236	894	1,881	1,423
67	1,647	1,743	2,236	894	1,881	1,461
68	1,668	1,764	2,263	906	1,902	1,519
69	1,705	1,802	2,312	925	1,946	1,590
70	1,749	1,849	2,372	950	1,995	1,672
71	1,802	1,905	2,445	978	2,056	1,723
72	1,857	1,964	2,520	1,007	2,120	1,776
73	1,919	2,029	2,602	1,040	2,189	1,835
74	1,985	2,100	2,693	1,078	2,266	1,898
75	2,057	2,177	2,793	1,117	2,349	1,968
76	2,129	2,252	2,890	1,156	2,431	2,036
77	2,203	2,329	2,988	1,195	2,513	2,106
78	2,274	2,404	3,085	1,234	2,595	2,174
79	2,347	2,484	3,186	1,274	2,679	2,245
80	2,422	2,560	3,285	1,315	2,764	2,315
81	2,499	2,641	3,389	1,356	2,851	2,389
82	2,575	2,724	3,496	1,398	2,941	2,463
83	2,655	2,808	3,604	1,441	3,030	2,538
84	2,735	2,895	3,714	1,486	3,123	2,617
85	2,831	2,995	3,845	1,536	3,232	2,707
86	2,912	3,082	3,953	1,582	3,325	2,786
87	2,996	3,167	4,065	1,626	3,419	2,865
88	3,079	3,257	4,179	1,671	3,515	2,944
89	3,165	3,347	4,295	1,719	3,614	3,026
90	3,253	3,441	4,413	1,766	3,712	3,110
91	3,339	3,533	4,533	1,814	3,813	3,193
92	3,432	3,629	4,655	1,863	3,916	3,281
93	3,523	3,725	4,779	1,912	4,020	3,368
94	3,615	3,822	4,907	1,963	4,127	3,456
95	3,710	3,923	5,033	2,015	4,234	3,547
96	3,805	4,025	5,164	2,066	4,343	3,639
97	3,902	4,128	5,295	2,118	4,455	3,732
98	4,000	4,233	5,430	2,172	4,567	3,827
99+	4,101	4,336	5,567	2,225	4,681	3,921

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

The above rates do not include the $20 one-time policy 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 Insurance Company

Annual Premiums

For Use in: Rest of State

Female Rates

Rates Effective 5/1/2018

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,102	1,166	1,496	598	1,258	926
66	1,102	1,166	1,496	598	1,258	952
67	1,102	1,166	1,496	598	1,258	977
68	1,116	1,180	1,514	606	1,273	1,016
69	1,140	1,205	1,546	619	1,301	1,064
70	1,170	1,237	1,587	635	1,335	1,119
71	1,205	1,274	1,635	654	1,375	1,152
72	1,242	1,314	1,686	674	1,418	1,188
73	1,283	1,357	1,741	696	1,464	1,226
74	1,328	1,405	1,802	721	1,516	1,270
75	1,376	1,456	1,868	747	1,571	1,317
76	1,425	1,507	1,933	773	1,626	1,362
77	1,473	1,558	1,999	799	1,681	1,409
78	1,521	1,608	2,064	825	1,736	1,454
79	1,570	1,661	2,131	852	1,792	1,502
80	1,620	1,713	2,198	879	1,849	1,549
81	1,671	1,767	2,267	907	1,907	1,598
82	1,723	1,822	2,338	935	1,967	1,648
83	1,776	1,878	2,410	964	2,027	1,698
84	1,830	1,936	2,484	994	2,089	1,750
85	1,894	2,003	2,571	1,028	2,162	1,811
86	1,948	2,061	2,644	1,058	2,224	1,863
87	2,004	2,119	2,719	1,088	2,287	1,916
88	2,060	2,179	2,795	1,118	2,351	1,970
89	2,117	2,239	2,873	1,149	2,417	2,024
90	2,175	2,301	2,952	1,181	2,483	2,080
91	2,234	2,363	3,032	1,213	2,551	2,136
92	2,295	2,427	3,114	1,246	2,619	2,194
93	2,356	2,492	3,197	1,279	2,689	2,253
94	2,418	2,557	3,282	1,313	2,760	2,312
95	2,481	2,624	3,367	1,347	2,832	2,372
96	2,545	2,692	3,454	1,382	2,905	2,434
97	2,610	2,761	3,542	1,417	2,980	2,496
98	2,676	2,831	3,632	1,453	3,055	2,560
99+	2,743	2,901	3,723	1,489	3,131	2,623

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,224	1,296	1,662	664	1,398	1,029
66	1,224	1,296	1,662	664	1,398	1,057
67	1,224	1,296	1,662	664	1,398	1,086
68	1,240	1,311	1,682	673	1,414	1,129
69	1,267	1,339	1,718	688	1,446	1,182
70	1,300	1,374	1,763	706	1,483	1,243
71	1,339	1,416	1,817	727	1,528	1,280
72	1,380	1,460	1,873	749	1,576	1,321
73	1,426	1,508	1,934	773	1,627	1,363
74	1,476	1,561	2,002	801	1,684	1,411
75	1,529	1,618	2,076	830	1,746	1,462
76	1,583	1,674	2,148	859	1,807	1,513
77	1,637	1,731	2,221	888	1,868	1,565
78	1,690	1,787	2,293	917	1,929	1,616
79	1,744	1,846	2,368	947	1,991	1,668
80	1,800	1,903	2,442	977	2,054	1,721
81	1,857	1,963	2,519	1,008	2,119	1,776
82	1,914	2,024	2,598	1,039	2,186	1,831
83	1,973	2,087	2,678	1,071	2,252	1,887
84	2,033	2,151	2,760	1,104	2,321	1,945
85	2,104	2,226	2,857	1,142	2,402	2,012
86	2,164	2,290	2,938	1,176	2,471	2,070
87	2,227	2,354	3,021	1,209	2,541	2,129
88	2,289	2,421	3,106	1,242	2,612	2,188
89	2,352	2,488	3,192	1,277	2,686	2,249
90	2,417	2,557	3,280	1,312	2,759	2,311
91	2,482	2,626	3,369	1,348	2,834	2,373
92	2,550	2,697	3,460	1,384	2,910	2,438
93	2,618	2,769	3,552	1,421	2,988	2,504
94	2,687	2,841	3,647	1,459	3,067	2,569
95	2,757	2,916	3,741	1,497	3,147	2,636
96	2,828	2,991	3,838	1,536	3,228	2,704
97	2,900	3,068	3,936	1,574	3,311	2,774
98	2,973	3,146	4,036	1,614	3,394	2,844
99+	3,048	3,223	4,137	1,654	3,479	2,915

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

The above rates do not include the $20 one-time policy 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 Insurance Company

Annual Premiums

For Use in: Rest of State

Male Rates

Rates Effective 5/1/2018

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,267	1,341	1,720	688	1,447	1,066
66	1,267	1,341	1,720	688	1,447	1,095
67	1,267	1,341	1,720	688	1,447	1,124
68	1,283	1,357	1,741	697	1,464	1,168
69	1,311	1,386	1,778	712	1,496	1,223
70	1,346	1,423	1,825	730	1,535	1,287
71	1,386	1,465	1,880	752	1,581	1,325
72	1,428	1,511	1,939	775	1,631	1,366
73	1,475	1,561	2,002	800	1,684	1,411
74	1,527	1,616	2,072	829	1,743	1,460
75	1,582	1,674	2,148	859	1,807	1,514
76	1,639	1,733	2,223	889	1,870	1,566
77	1,694	1,792	2,299	919	1,933	1,620
78	1,749	1,849	2,374	949	1,996	1,673
79	1,806	1,910	2,451	980	2,061	1,727
80	1,863	1,970	2,528	1,011	2,126	1,782
81	1,922	2,032	2,607	1,043	2,193	1,838
82	1,981	2,095	2,689	1,075	2,262	1,895
83	2,042	2,160	2,772	1,109	2,331	1,953
84	2,105	2,226	2,857	1,143	2,402	2,013
85	2,178	2,303	2,957	1,182	2,486	2,083
86	2,240	2,370	3,041	1,217	2,558	2,142
87	2,305	2,437	3,127	1,251	2,630	2,204
88	2,369	2,506	3,214	1,286	2,704	2,265
89	2,435	2,575	3,304	1,321	2,780	2,328
90	2,501	2,646	3,395	1,358	2,855	2,393
91	2,569	2,717	3,487	1,395	2,934	2,457
92	2,639	2,791	3,581	1,433	3,012	2,523
93	2,709	2,866	3,677	1,471	3,092	2,592
94	2,781	2,941	3,774	1,510	3,174	2,659
95	2,853	3,018	3,872	1,549	3,257	2,728
96	2,927	3,096	3,972	1,589	3,341	2,800
97	3,002	3,175	4,073	1,630	3,427	2,871
98	3,077	3,256	4,177	1,671	3,513	2,944
99+	3,154	3,336	4,281	1,712	3,601	3,016

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,408	1,490	1,911	764	1,608	1,184
66	1,408	1,490	1,911	764	1,608	1,216
67	1,408	1,490	1,911	764	1,608	1,249
68	1,426	1,508	1,934	774	1,626	1,298
69	1,457	1,540	1,976	791	1,663	1,359
70	1,495	1,580	2,027	812	1,705	1,429
71	1,540	1,628	2,090	836	1,757	1,473
72	1,587	1,679	2,154	861	1,812	1,518
73	1,640	1,734	2,224	889	1,871	1,568
74	1,697	1,795	2,302	921	1,937	1,622
75	1,758	1,861	2,387	955	2,008	1,682
76	1,820	1,925	2,470	988	2,078	1,740
77	1,883	1,991	2,554	1,021	2,148	1,800
78	1,944	2,055	2,637	1,055	2,218	1,858
79	2,006	2,123	2,723	1,089	2,290	1,919
80	2,070	2,188	2,808	1,124	2,362	1,979
81	2,136	2,257	2,897	1,159	2,437	2,042
82	2,201	2,328	2,988	1,195	2,514	2,105
83	2,269	2,400	3,080	1,232	2,590	2,169
84	2,338	2,474	3,174	1,270	2,669	2,237
85	2,420	2,560	3,286	1,313	2,762	2,314
86	2,489	2,634	3,379	1,352	2,842	2,381
87	2,561	2,707	3,474	1,390	2,922	2,449
88	2,632	2,784	3,572	1,428	3,004	2,516
89	2,705	2,861	3,671	1,469	3,089	2,586
90	2,780	2,941	3,772	1,509	3,173	2,658
91	2,854	3,020	3,874	1,550	3,259	2,729
92	2,933	3,102	3,979	1,592	3,347	2,804
93	3,011	3,184	4,085	1,634	3,436	2,879
94	3,090	3,267	4,194	1,678	3,527	2,954
95	3,171	3,353	4,302	1,722	3,619	3,032
96	3,252	3,440	4,414	1,766	3,712	3,110
97	3,335	3,528	4,526	1,810	3,808	3,190
98	3,419	3,618	4,641	1,856	3,903	3,271
99+	3,505	3,706	4,758	1,902	4,001	3,351

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

The above rates do not include the $20 one-time policyfee.

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 Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state. Premiums for this policy will increase due to the increase in your age. Upon attainment of an age requiring a rate increase, the renewal premium for the policy will be the renewal premium then in effect for your attained age. Other policies may be provided with Issue Age rating and do not increase with age. You should compare Issue Age with Attained Age policies.

Premiums payable other than annually will be determined according to the following factors:

Semi-annual: 0.5200 Quarterly: 0.2650
Monthly EFT: 0.0833.

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 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 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 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 $1340	$0	$1340 (Part A Deductible)
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	$0	Up to $167.50 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 co-payment/ 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 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 $183 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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare Approved amounts*	$0	$0	$183 (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 $1340	$1340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	$0	Up to $167.50 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 co-payment/ 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 B

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

* Once you have been billed $183 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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare Approved amounts*	$0	$0	$183 (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 $1340	$1340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	Up to $167.50 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 co-payment/ 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 F

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

*Once you have been billed $183 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 $183 of Medicare-Approved amounts*	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$183 (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 $183 of Medicare Approved amounts*	$0	$183 (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 $2240 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2240. 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 $2240 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2240 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1340	$1340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	Up to $167.50 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 co-payment/ 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.

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $183 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 $2240 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2240. 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 $2240 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2240 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 $183 of Medicare-Approved amounts*	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$183 (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 $2240 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2240 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $183 of Medicare Approved amounts*	$0	$183 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2240 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2240 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 $1340	$1340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	Up to $167.50 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 co-payment/ 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 G

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

*Once you have been billed $183 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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare Approved amounts*	$0	$0	$183 (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 $1340	$1340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	Up to $167.50 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 co-payment/ 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 $183 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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 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.
Part B Excess Charges (Above Medicare-Approved amounts)	$0	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare Approved amounts*	$0	$0	$183 (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