Aetna Health and Life Insurance Company

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Outline of Coverage

Medicare Supplement Insurance

BENEFIT PLANS A, B, F, HIGH DEDUCTIBLE F, G, N

Underwritten by

Aetna Health and Life Insurance Company

MICHIGAN

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Rates Effective: 11/2018 B

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

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

See Outlines of Coverage Sections for Details about ALL Plans

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

A	B	C	D	F/F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $5560; paid at 100% after limit reached	Out-of-pocket limit $2780 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 $2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2300. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Aetna Health and Life Insurance Company

Annual Premiums

For Use in ZIP Codes: 486-489, 492

Female Rates

Rates Effective 10/1/2018

Attained	Preferred						
Age	Plan A	Plan B	Plan C	Plan F	Plan HF	Plan G	Plan N
Under 65	---	---	3,453	---	---	---	---
65	1,094	1,285	1,643	1,652	661	1,286	1,091
66	1,094	1,285	1,643	1,652	661	1,286	1,091
67	1,094	1,285	1,643	1,652	661	1,286	1,091
68	1,107	1,301	1,663	1,673	669	1,302	1,104
69	1,131	1,329	1,699	1,709	684	1,331	1,128
70	1,161	1,364	1,743	1,754	701	1,365	1,158
71	1,196	1,405	1,796	1,806	723	1,406	1,192
72	1,233	1,449	1,852	1,863	745	1,450	1,229
73	1,273	1,496	1,912	1,923	769	1,497	1,269
74	1,318	1,549	1,980	1,990	796	1,550	1,314
75	1,366	1,605	2,052	2,063	825	1,607	1,362
76	1,414	1,661	2,123	2,135	854	1,663	1,409
77	1,461	1,717	2,195	2,208	883	1,719	1,457
78	1,509	1,773	2,266	2,279	912	1,774	1,504
79	1,558	1,832	2,340	2,353	942	1,833	1,554
80	1,607	1,889	2,414	2,428	971	1,891	1,603
81	1,658	1,948	2,490	2,505	1,001	1,950	1,652
82	1,710	2,009	2,567	2,582	1,032	2,011	1,704
83	1,763	2,071	2,647	2,662	1,065	2,074	1,757
84	1,817	2,135	2,728	2,743	1,097	2,136	1,811
85	1,880	2,209	2,823	2,839	1,135	2,211	1,874
86	1,933	2,272	2,904	2,920	1,169	2,274	1,928
87	1,988	2,337	2,986	3,002	1,201	2,339	1,982
88	2,044	2,402	3,069	3,087	1,234	2,404	2,038
89	2,101	2,469	3,155	3,173	1,269	2,471	2,094
90	2,159	2,537	3,242	3,261	1,304	2,539	2,152
91	2,217	2,606	3,330	3,349	1,339	2,608	2,211
92	2,278	2,676	3,419	3,439	1,376	2,678	2,270
93	2,338	2,748	3,511	3,531	1,413	2,750	2,331
94	2,400	2,820	3,604	3,623	1,449	2,823	2,392
95	2,462	2,893	3,698	3,718	1,487	2,897	2,455
96	2,526	2,968	3,793	3,815	1,526	2,971	2,517
97	2,591	3,045	3,890	3,912	1,565	3,047	2,582
98	2,656	3,121	3,988	4,011	1,605	3,124	2,647
99+	2,723	3,199	4,088	4,112	1,645	3,202	2,714

Attained	Standard						
Age	Plan A	Plan B	Plan C	Plan F	Plan HF	Plan G	Plan N
Under 65	---	---	3,836	---	---	---	---
65	1,216	1,428	1,825	1,836	734	1,429	1,212
66	1,216	1,428	1,825	1,836	734	1,429	1,212
67	1,216	1,428	1,825	1,836	734	1,429	1,212
68	1,230	1,446	1,848	1,859	743	1,447	1,227
69	1,256	1,477	1,888	1,899	759	1,479	1,253
70	1,290	1,515	1,936	1,948	779	1,516	1,286
71	1,328	1,562	1,996	2,007	802	1,563	1,325
72	1,371	1,610	2,058	2,070	828	1,611	1,365
73	1,415	1,662	2,124	2,137	854	1,663	1,410
74	1,464	1,720	2,200	2,212	885	1,722	1,460
75	1,518	1,783	2,280	2,292	917	1,785	1,513
76	1,570	1,846	2,359	2,373	949	1,848	1,566
77	1,623	1,908	2,439	2,453	982	1,911	1,619
78	1,676	1,970	2,517	2,532	1,013	1,972	1,672
79	1,731	2,035	2,601	2,615	1,047	2,037	1,727
80	1,785	2,098	2,682	2,698	1,079	2,102	1,781
81	1,842	2,164	2,767	2,783	1,112	2,168	1,836
82	1,900	2,232	2,852	2,870	1,147	2,235	1,893
83	1,958	2,301	2,941	2,958	1,184	2,304	1,953
84	2,019	2,373	3,032	3,048	1,219	2,374	2,012
85	2,089	2,454	3,136	3,155	1,261	2,456	2,082
86	2,148	2,525	3,227	3,244	1,298	2,527	2,142
87	2,210	2,596	3,318	3,336	1,335	2,600	2,202
88	2,271	2,669	3,411	3,430	1,372	2,671	2,265
89	2,334	2,743	3,506	3,525	1,410	2,745	2,326
90	2,399	2,819	3,603	3,622	1,448	2,821	2,391
91	2,463	2,895	3,700	3,722	1,488	2,898	2,456
92	2,530	2,973	3,799	3,821	1,529	2,976	2,523
93	2,598	3,053	3,901	3,923	1,569	3,055	2,590
94	2,667	3,133	4,005	4,026	1,610	3,136	2,658
95	2,736	3,215	4,108	4,132	1,652	3,218	2,728
96	2,807	3,297	4,214	4,238	1,696	3,302	2,797
97	2,879	3,383	4,322	4,346	1,739	3,385	2,870
98	2,951	3,468	4,431	4,457	1,783	3,471	2,941
99+	3,025	3,554	4,542	4,568	1,827	3,558	3,015

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 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 and Life Insurance Company

Annual Premiums

For Use in ZIP Codes: 486-489, 492

Male Rates

Rates Effective 10/1/2018

Attained Age	Preferred						
Age	Plan A	Plan B	Plan C	Plan F	Plan HF	Plan G	Plan N
Under 65	---	---	3,971	---	---	---	---
65	1,258	1,479	1,889	1,901	760	1,480	1,255
66	1,258	1,479	1,889	1,901	760	1,480	1,255
67	1,258	1,479	1,889	1,901	760	1,480	1,255
68	1,273	1,497	1,913	1,923	769	1,498	1,269
69	1,300	1,529	1,954	1,965	786	1,530	1,297
70	1,335	1,568	2,004	2,017	806	1,570	1,332
71	1,375	1,616	2,065	2,077	831	1,617	1,372
72	1,418	1,666	2,130	2,143	858	1,668	1,414
73	1,464	1,720	2,199	2,212	885	1,722	1,459
74	1,515	1,781	2,277	2,289	916	1,782	1,512
75	1,571	1,846	2,360	2,373	949	1,848	1,566
76	1,625	1,911	2,442	2,456	983	1,913	1,621
77	1,680	1,975	2,524	2,539	1,016	1,977	1,675
78	1,736	2,039	2,606	2,621	1,049	2,040	1,730
79	1,792	2,106	2,691	2,706	1,083	2,108	1,787
80	1,848	2,172	2,776	2,792	1,117	2,175	1,844
81	1,906	2,241	2,864	2,880	1,151	2,243	1,901
82	1,966	2,310	2,953	2,970	1,187	2,312	1,960
83	2,027	2,382	3,045	3,062	1,225	2,385	2,021
84	2,089	2,456	3,137	3,155	1,261	2,457	2,083
85	2,162	2,540	3,246	3,265	1,306	2,542	2,155
86	2,224	2,614	3,339	3,359	1,344	2,616	2,217
87	2,286	2,688	3,434	3,453	1,381	2,690	2,279
88	2,351	2,763	3,529	3,550	1,419	2,765	2,344
89	2,416	2,839	3,628	3,649	1,459	2,841	2,408
90	2,483	2,917	3,728	3,750	1,499	2,920	2,475
91	2,550	2,997	3,829	3,851	1,540	2,999	2,542
92	2,619	3,078	3,932	3,955	1,582	3,080	2,610
93	2,689	3,160	4,038	4,060	1,624	3,162	2,681
94	2,759	3,243	4,145	4,167	1,666	3,246	2,751
95	2,832	3,327	4,253	4,276	1,711	3,331	2,823
96	2,905	3,413	4,362	4,387	1,755	3,417	2,895
97	2,980	3,501	4,473	4,498	1,799	3,504	2,970
98	3,054	3,590	4,587	4,613	1,846	3,593	3,045
99+	3,131	3,678	4,701	4,728	1,891	3,683	3,121

Attained Age	Standard						
Age	Plan A	Plan B	Plan C	Plan F	Plan HF	Plan G	Plan N
Under 65	---	---	4,412	---	---	---	---
65	1,399	1,642	2,100	2,111	845	1,643	1,393
66	1,399	1,642	2,100	2,111	845	1,643	1,393
67	1,399	1,642	2,100	2,111	845	1,643	1,393
68	1,415	1,663	2,125	2,137	854	1,664	1,410
69	1,444	1,699	2,171	2,184	873	1,700	1,441
70	1,483	1,742	2,227	2,241	895	1,744	1,480
71	1,528	1,796	2,295	2,308	922	1,797	1,524
72	1,576	1,852	2,367	2,381	953	1,853	1,570
73	1,628	1,912	2,443	2,458	983	1,913	1,622
74	1,684	1,979	2,530	2,543	1,017	1,980	1,679
75	1,746	2,051	2,622	2,635	1,054	2,053	1,740
76	1,806	2,122	2,713	2,729	1,092	2,125	1,801
77	1,866	2,195	2,805	2,821	1,129	2,197	1,862
78	1,928	2,266	2,895	2,912	1,165	2,268	1,922
79	1,990	2,340	2,991	3,007	1,203	2,343	1,986
80	2,053	2,413	3,083	3,103	1,241	2,417	2,048
81	2,119	2,489	3,182	3,201	1,280	2,493	2,111
82	2,185	2,567	3,280	3,300	1,319	2,569	2,177
83	2,252	2,647	3,381	3,402	1,361	2,649	2,245
84	2,321	2,729	3,486	3,505	1,402	2,730	2,313
85	2,402	2,822	3,607	3,628	1,450	2,824	2,394
86	2,470	2,904	3,711	3,731	1,493	2,906	2,462
87	2,541	2,986	3,816	3,836	1,535	2,989	2,533
88	2,611	3,069	3,923	3,944	1,578	3,072	2,605
89	2,684	3,155	4,032	4,054	1,622	3,157	2,675
90	2,758	3,242	4,143	4,166	1,665	3,244	2,750
91	2,833	3,330	4,255	4,280	1,712	3,332	2,824
92	2,910	3,419	4,370	4,395	1,758	3,423	2,901
93	2,988	3,511	4,486	4,511	1,805	3,513	2,979
94	3,066	3,603	4,605	4,630	1,852	3,607	3,056
95	3,146	3,698	4,725	4,752	1,901	3,701	3,137
96	3,228	3,792	4,846	4,874	1,950	3,797	3,217
97	3,311	3,890	4,970	4,998	2,000	3,892	3,300
98	3,393	3,988	5,095	5,126	2,051	3,992	3,381
99+	3,479	4,088	5,224	5,254	2,102	4,091	3,468

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 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 and Life Insurance Company

Annual Premiums

For Use in ZIP Codes: 480-485

Female Rates

Rates Effective 10/1/2018

Attained	Preferred						
Age	Plan A	Plan B	Plan C	Plan F	Plan HF	Plan G	Plan N
Under 65	---	---	4,060	---	---	---	---
65	1,287	1,511	1,932	1,943	777	1,513	1,283
66	1,287	1,511	1,932	1,943	777	1,513	1,283
67	1,287	1,511	1,932	1,943	777	1,513	1,283
68	1,302	1,530	1,956	1,967	786	1,532	1,298
69	1,330	1,563	1,998	2,009	804	1,565	1,326
70	1,365	1,604	2,050	2,062	824	1,605	1,361
71	1,406	1,652	2,112	2,123	850	1,654	1,402
72	1,450	1,704	2,178	2,191	876	1,706	1,445
73	1,497	1,759	2,248	2,262	904	1,760	1,492
74	1,549	1,821	2,328	2,341	936	1,822	1,546
75	1,607	1,887	2,413	2,426	970	1,890	1,601
76	1,662	1,953	2,497	2,511	1,005	1,956	1,657
77	1,718	2,019	2,581	2,596	1,039	2,022	1,713
78	1,774	2,085	2,664	2,680	1,072	2,087	1,769
79	1,833	2,154	2,752	2,767	1,107	2,155	1,828
80	1,890	2,221	2,838	2,855	1,142	2,224	1,885
81	1,949	2,291	2,929	2,945	1,177	2,294	1,943
82	2,010	2,362	3,019	3,037	1,214	2,365	2,004
83	2,073	2,436	3,113	3,131	1,252	2,438	2,066
84	2,136	2,511	3,208	3,226	1,290	2,512	2,130
85	2,211	2,597	3,320	3,339	1,335	2,600	2,203
86	2,273	2,672	3,415	3,434	1,374	2,675	2,267
87	2,338	2,748	3,512	3,531	1,412	2,751	2,330
88	2,404	2,824	3,609	3,630	1,452	2,827	2,396
89	2,470	2,903	3,710	3,731	1,492	2,906	2,463
90	2,539	2,983	3,813	3,834	1,533	2,986	2,531
91	2,607	3,065	3,915	3,938	1,575	3,067	2,600
92	2,678	3,147	4,021	4,044	1,618	3,150	2,670
93	2,750	3,231	4,129	4,152	1,661	3,233	2,741
94	2,822	3,316	4,238	4,261	1,704	3,320	2,813
95	2,896	3,402	4,348	4,373	1,749	3,406	2,887
96	2,971	3,490	4,460	4,486	1,795	3,494	2,960
97	3,047	3,580	4,575	4,600	1,840	3,583	3,037
98	3,123	3,670	4,690	4,717	1,887	3,674	3,113
99+	3,202	3,762	4,807	4,835	1,934	3,766	3,192

Attained	Standard						
Age	Plan A	Plan B	Plan C	Plan F	Plan HF	Plan G	Plan N
Under 65	---	---	4,511	---	---	---	---
65	1,430	1,679	2,146	2,159	864	1,680	1,425
66	1,430	1,679	2,146	2,159	864	1,680	1,425
67	1,430	1,679	2,146	2,159	864	1,680	1,425
68	1,447	1,701	2,173	2,186	874	1,702	1,443
69	1,477	1,737	2,220	2,233	893	1,739	1,473
70	1,516	1,782	2,277	2,291	916	1,783	1,513
71	1,562	1,836	2,347	2,360	944	1,838	1,558
72	1,612	1,894	2,421	2,435	974	1,895	1,605
73	1,664	1,955	2,498	2,513	1,005	1,956	1,659
74	1,722	2,023	2,587	2,601	1,040	2,024	1,717
75	1,786	2,097	2,681	2,695	1,078	2,099	1,779
76	1,847	2,170	2,774	2,790	1,116	2,173	1,842
77	1,909	2,244	2,868	2,884	1,154	2,247	1,904
78	1,971	2,316	2,960	2,977	1,191	2,319	1,966
79	2,036	2,393	3,058	3,075	1,231	2,395	2,031
80	2,099	2,468	3,153	3,172	1,269	2,471	2,094
81	2,167	2,545	3,254	3,273	1,308	2,549	2,159
82	2,234	2,625	3,354	3,374	1,349	2,628	2,226
83	2,303	2,706	3,458	3,479	1,392	2,709	2,296
84	2,374	2,790	3,565	3,584	1,434	2,791	2,366
85	2,456	2,885	3,688	3,710	1,483	2,888	2,449
86	2,526	2,969	3,795	3,815	1,527	2,972	2,518
87	2,598	3,053	3,901	3,923	1,570	3,057	2,590
88	2,671	3,138	4,011	4,034	1,613	3,141	2,663
89	2,744	3,226	4,122	4,145	1,659	3,228	2,736
90	2,821	3,315	4,237	4,260	1,703	3,317	2,812
91	2,897	3,405	4,351	4,376	1,750	3,407	2,888
92	2,976	3,496	4,468	4,493	1,798	3,500	2,967
93	3,056	3,590	4,587	4,613	1,845	3,593	3,045
94	3,136	3,684	4,709	4,735	1,894	3,688	3,125
95	3,217	3,781	4,831	4,859	1,943	3,785	3,208
96	3,301	3,877	4,956	4,983	1,994	3,882	3,289
97	3,386	3,978	5,083	5,110	2,045	3,980	3,374
98	3,470	4,078	5,211	5,241	2,097	4,082	3,458
99+	3,557	4,180	5,342	5,372	2,149	4,183	3,546

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 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 and Life Insurance Company

Annual Premiums

For Use in ZIP Codes: 480-485

Male Rates

Rates Effective 10/1/2018

Attained	Preferred						
Age	Plan A	Plan B	Plan C	Plan F	Plan HF	Plan G	Plan N
Under 65	---	---	4,670	---	---	---	---
65	1,480	1,739	2,221	2,235	894	1,740	1,476
66	1,480	1,739	2,221	2,235	894	1,740	1,476
67	1,480	1,739	2,221	2,235	894	1,740	1,476
68	1,497	1,760	2,249	2,262	904	1,761	1,492
69	1,529	1,798	2,297	2,310	925	1,800	1,525
70	1,570	1,844	2,357	2,372	947	1,847	1,566
71	1,617	1,900	2,428	2,442	977	1,901	1,613
72	1,668	1,960	2,504	2,520	1,008	1,961	1,662
73	1,722	2,023	2,586	2,601	1,040	2,024	1,716
74	1,782	2,094	2,677	2,691	1,077	2,096	1,778
75	1,848	2,170	2,775	2,790	1,116	2,173	1,842
76	1,911	2,247	2,871	2,888	1,156	2,249	1,906
77	1,976	2,323	2,968	2,986	1,195	2,325	1,970
78	2,041	2,398	3,065	3,082	1,233	2,399	2,035
79	2,107	2,477	3,165	3,183	1,274	2,479	2,102
80	2,173	2,554	3,264	3,283	1,313	2,558	2,168
81	2,242	2,635	3,368	3,387	1,354	2,638	2,235
82	2,311	2,717	3,472	3,493	1,396	2,719	2,305
83	2,384	2,802	3,580	3,600	1,440	2,804	2,376
84	2,456	2,888	3,689	3,710	1,483	2,889	2,450
85	2,543	2,987	3,818	3,839	1,535	2,990	2,534
86	2,615	3,073	3,927	3,950	1,580	3,076	2,607
87	2,689	3,161	4,039	4,060	1,624	3,164	2,680
88	2,765	3,249	4,150	4,174	1,669	3,251	2,756
89	2,841	3,339	4,266	4,291	1,716	3,341	2,832
90	2,920	3,430	4,384	4,409	1,763	3,434	2,911
91	2,998	3,524	4,502	4,529	1,811	3,527	2,990
92	3,080	3,620	4,624	4,651	1,861	3,622	3,070
93	3,162	3,716	4,749	4,774	1,910	3,719	3,152
94	3,245	3,814	4,874	4,900	1,960	3,818	3,235
95	3,330	3,913	5,001	5,028	2,012	3,917	3,320
96	3,416	4,013	5,130	5,159	2,064	4,018	3,405
97	3,504	4,117	5,260	5,290	2,116	4,120	3,493
98	3,592	4,221	5,394	5,424	2,170	4,225	3,580
99+	3,682	4,326	5,528	5,560	2,224	4,331	3,670

Attained	Standard						
Age	Plan A	Plan B	Plan C	Plan F	Plan HF	Plan G	Plan N
Under 65	---	---	5,188	---	---	---	---
65	1,645	1,930	2,469	2,483	993	1,932	1,638
66	1,645	1,930	2,469	2,483	993	1,932	1,638
67	1,645	1,930	2,469	2,483	993	1,932	1,638
68	1,664	1,956	2,499	2,513	1,005	1,957	1,659
69	1,698	1,998	2,553	2,568	1,026	1,999	1,694
70	1,744	2,049	2,619	2,635	1,053	2,051	1,740
71	1,797	2,112	2,699	2,714	1,085	2,113	1,792
72	1,853	2,178	2,784	2,800	1,120	2,179	1,847
73	1,914	2,248	2,873	2,891	1,156	2,249	1,908
74	1,980	2,327	2,976	2,991	1,196	2,328	1,975
75	2,054	2,412	3,084	3,099	1,240	2,414	2,046
76	2,123	2,496	3,190	3,209	1,284	2,499	2,118
77	2,195	2,581	3,298	3,317	1,327	2,583	2,189
78	2,267	2,664	3,405	3,424	1,370	2,667	2,261
79	2,341	2,752	3,517	3,536	1,415	2,755	2,336
80	2,414	2,837	3,626	3,649	1,459	2,842	2,408
81	2,492	2,927	3,741	3,764	1,505	2,931	2,483
82	2,569	3,019	3,857	3,881	1,551	3,021	2,560
83	2,648	3,113	3,976	4,001	1,600	3,115	2,640
84	2,729	3,209	4,100	4,121	1,648	3,211	2,720
85	2,824	3,319	4,242	4,266	1,706	3,321	2,816
86	2,904	3,415	4,364	4,388	1,755	3,418	2,896
87	2,988	3,512	4,487	4,511	1,805	3,515	2,978
88	3,071	3,609	4,613	4,638	1,855	3,612	3,063
89	3,156	3,710	4,741	4,768	1,908	3,712	3,146
90	3,244	3,813	4,872	4,898	1,958	3,815	3,233
91	3,331	3,915	5,004	5,033	2,013	3,918	3,321
92	3,421	4,021	5,138	5,168	2,068	4,025	3,411
93	3,514	4,129	5,276	5,305	2,122	4,131	3,503
94	3,606	4,237	5,415	5,444	2,178	4,242	3,594
95	3,700	4,348	5,556	5,588	2,235	4,352	3,689
96	3,796	4,459	5,698	5,732	2,294	4,465	3,783
97	3,894	4,575	5,845	5,878	2,352	4,577	3,881
98	3,990	4,690	5,992	6,027	2,412	4,694	3,976
99+	4,091	4,807	6,143	6,179	2,471	4,811	4,078

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 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 and Life Insurance Company

Annual Premiums

For Use in: Rest of State

Female Rates

Rates Effective 10/1/2018

Attained	Preferred						
Age	Plan A	Plan B	Plan C	Plan F	Plan HF	Plan G	Plan N
Under 65	---	---	3,325	---	---	---	---
65	1,054	1,238	1,582	1,591	636	1,239	1,050
66	1,054	1,238	1,582	1,591	636	1,239	1,050
67	1,054	1,238	1,582	1,591	636	1,239	1,050
68	1,066	1,253	1,602	1,611	644	1,254	1,063
69	1,089	1,280	1,636	1,645	658	1,281	1,086
70	1,118	1,314	1,679	1,689	675	1,315	1,115
71	1,151	1,353	1,730	1,739	696	1,354	1,148
72	1,188	1,396	1,784	1,794	718	1,397	1,184
73	1,226	1,440	1,841	1,852	740	1,441	1,222
74	1,269	1,491	1,906	1,917	766	1,492	1,266
75	1,316	1,545	1,976	1,986	795	1,548	1,311
76	1,361	1,600	2,045	2,056	823	1,602	1,357
77	1,407	1,654	2,113	2,126	851	1,656	1,403
78	1,453	1,708	2,182	2,194	878	1,709	1,449
79	1,501	1,764	2,254	2,266	907	1,765	1,497
80	1,548	1,819	2,324	2,338	935	1,821	1,543
81	1,596	1,876	2,398	2,412	964	1,878	1,591
82	1,646	1,934	2,472	2,487	994	1,936	1,641
83	1,697	1,995	2,549	2,564	1,025	1,997	1,692
84	1,749	2,056	2,627	2,642	1,057	2,057	1,744
85	1,811	2,127	2,719	2,734	1,093	2,129	1,804
86	1,862	2,188	2,797	2,812	1,125	2,190	1,856
87	1,915	2,251	2,876	2,891	1,156	2,253	1,908
88	1,969	2,313	2,956	2,972	1,189	2,315	1,962
89	2,023	2,377	3,038	3,056	1,222	2,380	2,017
90	2,079	2,443	3,122	3,140	1,255	2,445	2,073
91	2,135	2,510	3,206	3,225	1,290	2,512	2,129
92	2,193	2,577	3,293	3,311	1,325	2,579	2,186
93	2,252	2,646	3,381	3,400	1,360	2,648	2,244
94	2,311	2,715	3,470	3,489	1,396	2,719	2,304
95	2,371	2,786	3,561	3,581	1,432	2,789	2,364
96	2,433	2,858	3,652	3,673	1,470	2,861	2,424
97	2,495	2,932	3,746	3,767	1,507	2,934	2,487
98	2,557	3,006	3,841	3,863	1,545	3,009	2,549
99+	2,622	3,080	3,936	3,959	1,584	3,084	2,614

Attained	Standard						
Age	Plan A	Plan B	Plan C	Plan F	Plan HF	Plan G	Plan N
Under 65	---	---	3,694	---	---	---	---
65	1,171	1,375	1,758	1,768	707	1,376	1,167
66	1,171	1,375	1,758	1,768	707	1,376	1,167
67	1,171	1,375	1,758	1,768	707	1,376	1,167
68	1,185	1,393	1,779	1,790	716	1,394	1,181
69	1,210	1,423	1,818	1,828	731	1,424	1,206
70	1,242	1,459	1,865	1,876	750	1,460	1,239
71	1,279	1,504	1,922	1,932	773	1,505	1,276
72	1,320	1,551	1,982	1,994	798	1,552	1,315
73	1,362	1,601	2,046	2,058	823	1,602	1,358
74	1,410	1,657	2,118	2,130	852	1,658	1,406
75	1,462	1,717	2,195	2,207	883	1,719	1,457
76	1,512	1,777	2,271	2,285	914	1,779	1,508
77	1,563	1,838	2,348	2,362	945	1,840	1,559
78	1,614	1,897	2,424	2,438	976	1,899	1,610
79	1,667	1,959	2,504	2,518	1,008	1,961	1,663
80	1,719	2,021	2,582	2,598	1,039	2,024	1,715
81	1,774	2,084	2,664	2,680	1,071	2,087	1,768
82	1,829	2,150	2,747	2,763	1,104	2,152	1,823
83	1,886	2,216	2,832	2,849	1,140	2,218	1,880
84	1,944	2,285	2,919	2,935	1,174	2,286	1,938
85	2,011	2,363	3,020	3,038	1,215	2,365	2,005
86	2,069	2,432	3,108	3,124	1,250	2,434	2,062
87	2,128	2,500	3,195	3,213	1,285	2,503	2,121
88	2,187	2,570	3,284	3,303	1,321	2,572	2,181
89	2,247	2,642	3,376	3,395	1,358	2,644	2,240
90	2,310	2,714	3,469	3,488	1,395	2,716	2,303
91	2,372	2,788	3,563	3,584	1,433	2,790	2,365
92	2,437	2,863	3,659	3,680	1,473	2,866	2,429
93	2,502	2,940	3,756	3,777	1,511	2,942	2,494
94	2,568	3,017	3,856	3,877	1,551	3,020	2,559
95	2,634	3,096	3,956	3,979	1,591	3,099	2,627
96	2,703	3,175	4,058	4,081	1,633	3,179	2,694
97	2,773	3,257	4,162	4,185	1,674	3,259	2,763
98	2,841	3,339	4,267	4,292	1,717	3,343	2,832
99+	2,913	3,423	4,374	4,399	1,760	3,426	2,904

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 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 and Life Insurance Company

Annual Premiums

For Use in: Rest of State

Male Rates

Rates Effective 10/1/2018

Attained	Preferred							Attained	Standard						
Age	Plan A	Plan B	Plan C	Plan F	Plan HF	Plan G	Plan N	Age	Plan A	Plan B	Plan C	Plan F	Plan HF	Plan G	Plan N
Under 65	---	---	3,824	---	---	---	---	Under 65	---	---	4,248	---	---	---	---
65	1,212	1,424	1,819	1,830	732	1,425	1,208	65	1,347	1,581	2,022	2,033	813	1,582	1,342
66	1,212	1,424	1,819	1,830	732	1,425	1,208	66	1,347	1,581	2,022	2,033	813	1,582	1,342
67	1,212	1,424	1,819	1,830	732	1,425	1,208	67	1,347	1,581	2,022	2,033	813	1,582	1,342
68	1,226	1,441	1,842	1,852	740	1,442	1,222	68	1,362	1,602	2,047	2,058	823	1,603	1,358
69	1,252	1,473	1,881	1,892	757	1,474	1,249	69	1,390	1,636	2,090	2,103	840	1,637	1,387
70	1,285	1,510	1,930	1,943	776	1,512	1,282	70	1,428	1,678	2,144	2,158	862	1,680	1,425
71	1,324	1,556	1,988	2,000	800	1,557	1,321	71	1,472	1,730	2,210	2,222	888	1,731	1,467
72	1,366	1,605	2,051	2,063	826	1,606	1,361	72	1,517	1,784	2,280	2,293	917	1,785	1,512
73	1,410	1,657	2,117	2,130	852	1,658	1,405	73	1,567	1,841	2,352	2,367	946	1,842	1,562
74	1,459	1,715	2,192	2,204	882	1,716	1,456	74	1,621	1,905	2,437	2,449	980	1,906	1,617
75	1,513	1,777	2,272	2,285	914	1,779	1,508	75	1,682	1,975	2,525	2,538	1,015	1,977	1,675
76	1,565	1,840	2,351	2,365	946	1,842	1,561	76	1,739	2,044	2,612	2,628	1,051	2,047	1,735
77	1,618	1,902	2,430	2,445	979	1,904	1,613	77	1,797	2,113	2,701	2,716	1,087	2,115	1,793
78	1,671	1,964	2,510	2,524	1,010	1,965	1,666	78	1,856	2,182	2,788	2,804	1,122	2,184	1,851
79	1,725	2,028	2,592	2,606	1,043	2,030	1,721	79	1,917	2,254	2,880	2,895	1,159	2,256	1,913
80	1,779	2,091	2,673	2,688	1,075	2,095	1,775	80	1,977	2,323	2,969	2,988	1,195	2,328	1,972
81	1,836	2,158	2,758	2,774	1,109	2,160	1,830	81	2,040	2,397	3,064	3,083	1,232	2,400	2,033
82	1,893	2,225	2,843	2,860	1,143	2,227	1,888	82	2,104	2,472	3,158	3,178	1,270	2,474	2,097
83	1,952	2,294	2,932	2,948	1,179	2,296	1,946	83	2,168	2,549	3,256	3,276	1,310	2,551	2,162
84	2,011	2,365	3,021	3,038	1,215	2,366	2,006	84	2,235	2,628	3,357	3,375	1,350	2,629	2,228
85	2,082	2,446	3,126	3,144	1,257	2,448	2,075	85	2,313	2,718	3,474	3,493	1,397	2,720	2,306
86	2,141	2,517	3,216	3,234	1,294	2,519	2,135	86	2,378	2,797	3,573	3,593	1,437	2,799	2,371
87	2,202	2,589	3,307	3,325	1,330	2,591	2,194	87	2,447	2,876	3,674	3,694	1,478	2,879	2,439
88	2,264	2,660	3,399	3,418	1,367	2,662	2,257	88	2,515	2,956	3,777	3,798	1,519	2,958	2,508
89	2,326	2,734	3,493	3,514	1,405	2,736	2,319	89	2,584	3,038	3,882	3,904	1,562	3,040	2,576
90	2,391	2,809	3,590	3,611	1,444	2,812	2,384	90	2,656	3,122	3,989	4,011	1,604	3,124	2,648
91	2,455	2,886	3,687	3,709	1,483	2,888	2,448	91	2,728	3,206	4,098	4,122	1,648	3,208	2,720
92	2,522	2,964	3,787	3,808	1,524	2,966	2,514	92	2,802	3,293	4,208	4,232	1,693	3,296	2,793
93	2,590	3,043	3,889	3,909	1,564	3,045	2,581	93	2,878	3,381	4,320	4,344	1,738	3,383	2,868
94	2,657	3,123	3,992	4,012	1,605	3,126	2,649	94	2,953	3,469	4,435	4,458	1,784	3,474	2,943
95	2,727	3,204	4,096	4,117	1,647	3,207	2,719	95	3,030	3,561	4,550	4,576	1,830	3,564	3,021
96	2,798	3,286	4,201	4,224	1,690	3,291	2,788	96	3,109	3,651	4,666	4,694	1,878	3,657	3,098
97	2,869	3,372	4,308	4,332	1,733	3,374	2,860	97	3,189	3,746	4,786	4,813	1,926	3,748	3,178
98	2,941	3,457	4,417	4,442	1,777	3,460	2,932	98	3,268	3,841	4,907	4,936	1,975	3,844	3,256
99+	3,015	3,542	4,527	4,553	1,821	3,546	3,006	99+	3,350	3,936	5,030	5,060	2,024	3,940	3,339

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

PREMIUM INFORMATION

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

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

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

DISCLOSURES

Use this outline to compare benefits and premium among policies.

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 Health and Life Insurance Company Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (b) be someone with whom you are in a civil union partnership; and (c) be 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.

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, C, 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 $1364	$0	$1364 (Part A Deductible)
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	$0	Up to $170.50 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 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 $185 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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	$0	Up to $170.50 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 copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN B

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

* Once you have been billed $185 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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN C

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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $$341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN C

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

*Once you have been billed $185 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 $185 of Medicare-Approved amounts*	$0	$185 (Part B Deductible)	$0
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 $185 of Medicare-Approved amounts*	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$185 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN C

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 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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN F

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

*Once you have been billed $185 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 $185 of Medicare-Approved amounts*	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$185 (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 $2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2300. 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 $2300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2300 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $185 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 $2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2300. 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 $2300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2300 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 $185 of Medicare-Approved amounts*	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$185 (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 $2300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2300 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $185 of Medicare Approved amounts*	$0	$185 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2300 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2300 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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN G

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

*Once you have been billed $185 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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 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 copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

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

PLAN N

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

*Once you have been billed $185 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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (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