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, HF, G, & N

Insured by

An Aetna Company **Aetna Health Insurance Company**

Ohio

AHCMS03883OH

Rates Effective: 02/2019 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 $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 Insurance Company

Annual Premiums

For Use in ZIP Codes: 436 and 440-445

Female Rates

Rates Effective 2/1/2019

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,405	1,487	1,908	763	1,472	1,083
66	1,405	1,487	1,908	763	1,472	1,114
67	1,405	1,487	1,908	763	1,472	1,143
68	1,423	1,505	1,931	773	1,489	1,189
69	1,454	1,536	1,971	790	1,522	1,245
70	1,492	1,577	2,024	810	1,562	1,309
71	1,536	1,625	2,085	834	1,609	1,348
72	1,584	1,675	2,150	860	1,659	1,390
73	1,636	1,730	2,221	888	1,713	1,434
74	1,694	1,791	2,298	920	1,774	1,486
75	1,755	1,857	2,382	952	1,838	1,541
76	1,817	1,922	2,465	986	1,902	1,594
77	1,879	1,987	2,549	1,019	1,967	1,649
78	1,940	2,051	2,633	1,052	2,031	1,701
79	2,002	2,118	2,718	1,087	2,097	1,757
80	2,066	2,184	2,803	1,121	2,163	1,812
81	2,131	2,253	2,891	1,157	2,231	1,870
82	2,197	2,324	2,981	1,192	2,301	1,928
83	2,265	2,395	3,074	1,230	2,372	1,987
84	2,334	2,469	3,168	1,267	2,444	2,048
85	2,415	2,554	3,278	1,312	2,530	2,119
86	2,484	2,628	3,372	1,349	2,602	2,180
87	2,555	2,703	3,468	1,388	2,676	2,242
88	2,627	2,779	3,565	1,426	2,751	2,305
89	2,700	2,856	3,664	1,465	2,828	2,368
90	2,774	2,934	3,765	1,506	2,905	2,434
91	2,849	3,014	3,867	1,547	2,985	2,499
92	2,927	3,095	3,971	1,589	3,064	2,567
93	3,005	3,178	4,077	1,631	3,146	2,636
94	3,084	3,261	4,185	1,674	3,229	2,705
95	3,164	3,346	4,294	1,718	3,313	2,775
96	3,246	3,433	4,405	1,762	3,399	2,848
97	3,329	3,521	4,517	1,808	3,487	2,920
98	3,413	3,611	4,632	1,853	3,574	2,995
99+	3,498	3,700	4,748	1,899	3,663	3,069

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,561	1,653	2,120	847	1,636	1,204
66	1,561	1,653	2,120	847	1,636	1,237
67	1,561	1,653	2,120	847	1,636	1,271
68	1,582	1,672	2,145	859	1,654	1,321
69	1,616	1,708	2,191	878	1,692	1,383
70	1,658	1,753	2,249	901	1,735	1,454
71	1,708	1,805	2,318	927	1,788	1,498
72	1,760	1,861	2,389	955	1,844	1,546
73	1,818	1,923	2,466	986	1,904	1,595
74	1,883	1,990	2,553	1,021	1,970	1,651
75	1,950	2,064	2,648	1,059	2,043	1,711
76	2,018	2,135	2,739	1,095	2,114	1,770
77	2,087	2,208	2,833	1,133	2,186	1,831
78	2,155	2,279	2,924	1,170	2,257	1,891
79	2,224	2,354	3,020	1,207	2,329	1,952
80	2,296	2,427	3,115	1,246	2,403	2,014
81	2,368	2,504	3,213	1,286	2,479	2,078
82	2,441	2,581	3,313	1,326	2,558	2,142
83	2,517	2,662	3,415	1,365	2,635	2,208
84	2,593	2,744	3,519	1,408	2,716	2,276
85	2,683	2,838	3,643	1,457	2,810	2,354
86	2,760	2,920	3,746	1,500	2,891	2,422
87	2,840	3,002	3,853	1,542	2,973	2,491
88	2,919	3,088	3,962	1,584	3,056	2,560
89	3,000	3,173	4,070	1,629	3,143	2,631
90	3,083	3,261	4,183	1,673	3,228	2,704
91	3,165	3,349	4,296	1,719	3,316	2,776
92	3,253	3,440	4,412	1,766	3,405	2,852
93	3,339	3,531	4,530	1,812	3,496	2,930
94	3,427	3,623	4,651	1,860	3,588	3,006
95	3,516	3,718	4,771	1,909	3,682	3,084
96	3,607	3,814	4,894	1,959	3,777	3,164
97	3,698	3,912	5,019	2,008	3,874	3,246
98	3,792	4,012	5,147	2,058	3,971	3,327
99+	3,887	4,110	5,276	2,110	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 2/1/2019

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,616	1,711	2,194	878	1,693	1,247
66	1,616	1,711	2,194	878	1,693	1,281
67	1,616	1,711	2,194	878	1,693	1,315
68	1,636	1,730	2,221	889	1,713	1,367
69	1,672	1,768	2,267	908	1,750	1,431
70	1,716	1,815	2,327	931	1,796	1,506
71	1,768	1,868	2,397	959	1,850	1,550
72	1,822	1,927	2,473	989	1,908	1,598
73	1,881	1,990	2,553	1,020	1,970	1,651
74	1,947	2,060	2,642	1,058	2,039	1,708
75	2,017	2,135	2,739	1,095	2,114	1,771
76	2,091	2,210	2,835	1,134	2,188	1,832
77	2,160	2,285	2,932	1,172	2,262	1,895
78	2,230	2,358	3,028	1,210	2,335	1,957
79	2,304	2,436	3,126	1,250	2,411	2,021
80	2,376	2,512	3,225	1,289	2,487	2,085
81	2,451	2,592	3,325	1,330	2,566	2,150
82	2,526	2,672	3,429	1,371	2,647	2,217
83	2,604	2,754	3,535	1,415	2,727	2,285
84	2,684	2,838	3,643	1,458	2,810	2,355
85	2,778	2,937	3,771	1,507	2,909	2,437
86	2,857	3,022	3,879	1,553	2,993	2,506
87	2,939	3,108	3,987	1,596	3,077	2,579
88	3,021	3,196	4,099	1,640	3,164	2,650
89	3,105	3,284	4,213	1,685	3,253	2,724
90	3,189	3,374	4,330	1,732	3,340	2,800
91	3,276	3,466	4,447	1,780	3,433	2,875
92	3,366	3,559	4,567	1,828	3,524	2,952
93	3,455	3,655	4,689	1,876	3,618	3,033
94	3,546	3,751	4,813	1,926	3,714	3,111
95	3,639	3,849	4,937	1,975	3,811	3,192
96	3,732	3,949	5,065	2,026	3,909	3,276
97	3,828	4,049	5,195	2,079	4,010	3,359
98	3,924	4,152	5,327	2,131	4,110	3,444
99+	4,022	4,254	5,459	2,183	4,213	3,529

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,796	1,900	2,437	975	1,881	1,385
66	1,796	1,900	2,437	975	1,881	1,423
67	1,796	1,900	2,437	975	1,881	1,461
68	1,818	1,923	2,466	987	1,902	1,519
69	1,858	1,964	2,520	1,009	1,946	1,590
70	1,907	2,015	2,585	1,035	1,995	1,672
71	1,964	2,077	2,665	1,066	2,056	1,723
72	2,024	2,141	2,747	1,097	2,120	1,776
73	2,092	2,211	2,836	1,134	2,189	1,835
74	2,165	2,290	2,936	1,175	2,266	1,898
75	2,242	2,373	3,044	1,218	2,349	1,968
76	2,321	2,455	3,150	1,260	2,431	2,036
77	2,401	2,539	3,257	1,302	2,513	2,106
78	2,479	2,621	3,363	1,346	2,595	2,174
79	2,559	2,707	3,473	1,389	2,679	2,245
80	2,640	2,790	3,581	1,433	2,764	2,315
81	2,724	2,878	3,695	1,478	2,851	2,389
82	2,807	2,969	3,811	1,525	2,941	2,463
83	2,893	3,061	3,928	1,571	3,030	2,538
84	2,981	3,155	4,048	1,619	3,123	2,617
85	3,086	3,264	4,191	1,674	3,232	2,707
86	3,174	3,359	4,309	1,725	3,325	2,786
87	3,265	3,453	4,431	1,773	3,419	2,865
88	3,357	3,551	4,555	1,822	3,515	2,944
89	3,449	3,648	4,681	1,873	3,614	3,026
90	3,545	3,751	4,810	1,925	3,712	3,110
91	3,640	3,852	4,941	1,977	3,813	3,193
92	3,740	3,956	5,074	2,030	3,916	3,281
93	3,840	4,061	5,210	2,084	4,020	3,368
94	3,941	4,166	5,348	2,140	4,127	3,456
95	4,044	4,276	5,486	2,196	4,234	3,547
96	4,148	4,388	5,629	2,252	4,343	3,639
97	4,253	4,500	5,772	2,308	4,455	3,732
98	4,361	4,614	5,919	2,367	4,567	3,827
99+	4,469	4,727	6,068	2,425	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 ZIP Codes: 450-454 and 459

Female Rates

Rates Effective 2/1/2019

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,261	1,335	1,713	685	1,321	972
66	1,261	1,335	1,713	685	1,321	1,000
67	1,261	1,335	1,713	685	1,321	1,026
68	1,277	1,350	1,733	694	1,337	1,067
69	1,305	1,379	1,769	709	1,366	1,117
70	1,339	1,415	1,817	727	1,402	1,175
71	1,379	1,458	1,871	749	1,444	1,210
72	1,422	1,504	1,930	772	1,489	1,247
73	1,468	1,553	1,993	797	1,537	1,287
74	1,520	1,608	2,062	825	1,592	1,334
75	1,575	1,666	2,138	855	1,650	1,383
76	1,631	1,725	2,212	885	1,707	1,430
77	1,686	1,783	2,288	915	1,765	1,479
78	1,741	1,841	2,363	944	1,823	1,527
79	1,797	1,901	2,439	975	1,882	1,577
80	1,854	1,960	2,516	1,006	1,941	1,626
81	1,912	2,022	2,595	1,038	2,002	1,678
82	1,972	2,085	2,675	1,070	2,065	1,730
83	2,033	2,149	2,758	1,104	2,128	1,783
84	2,095	2,216	2,843	1,137	2,193	1,838
85	2,167	2,292	2,942	1,177	2,270	1,902
86	2,229	2,358	3,026	1,211	2,335	1,956
87	2,293	2,426	3,112	1,245	2,401	2,012
88	2,357	2,494	3,199	1,280	2,469	2,069
89	2,423	2,563	3,289	1,315	2,538	2,125
90	2,490	2,633	3,379	1,351	2,607	2,184
91	2,557	2,705	3,470	1,388	2,679	2,243
92	2,627	2,777	3,564	1,426	2,750	2,304
93	2,696	2,852	3,659	1,464	2,823	2,366
94	2,768	2,926	3,756	1,503	2,898	2,428
95	2,839	3,003	3,854	1,541	2,974	2,491
96	2,913	3,081	3,953	1,581	3,050	2,556
97	2,987	3,159	4,054	1,622	3,129	2,621
98	3,063	3,240	4,157	1,663	3,208	2,688
99+	3,140	3,320	4,261	1,704	3,288	2,754

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,401	1,484	1,903	760	1,468	1,080
66	1,401	1,484	1,903	760	1,468	1,110
67	1,401	1,484	1,903	760	1,468	1,140
68	1,420	1,500	1,925	771	1,485	1,185
69	1,450	1,533	1,967	788	1,518	1,241
70	1,488	1,573	2,018	809	1,557	1,305
71	1,533	1,620	2,080	832	1,604	1,344
72	1,579	1,671	2,144	857	1,655	1,387
73	1,632	1,726	2,213	885	1,708	1,431
74	1,689	1,786	2,291	917	1,768	1,482
75	1,750	1,852	2,376	950	1,833	1,535
76	1,811	1,916	2,458	983	1,897	1,589
77	1,873	1,981	2,542	1,016	1,961	1,643
78	1,934	2,045	2,624	1,050	2,025	1,697
79	1,996	2,113	2,710	1,084	2,091	1,751
80	2,060	2,178	2,795	1,118	2,157	1,807
81	2,125	2,247	2,883	1,154	2,225	1,865
82	2,190	2,316	2,974	1,190	2,295	1,923
83	2,259	2,389	3,065	1,225	2,365	1,981
84	2,327	2,462	3,158	1,263	2,437	2,042
85	2,408	2,547	3,270	1,307	2,522	2,113
86	2,477	2,621	3,362	1,346	2,595	2,174
87	2,548	2,694	3,458	1,384	2,668	2,235
88	2,620	2,771	3,555	1,422	2,743	2,297
89	2,692	2,848	3,653	1,462	2,820	2,361
90	2,767	2,926	3,754	1,502	2,897	2,427
91	2,840	3,005	3,856	1,542	2,976	2,492
92	2,919	3,087	3,960	1,584	3,056	2,560
93	2,997	3,169	4,066	1,626	3,137	2,629
94	3,075	3,252	4,174	1,670	3,220	2,697
95	3,155	3,337	4,282	1,714	3,304	2,768
96	3,237	3,423	4,392	1,758	3,389	2,839
97	3,319	3,511	4,505	1,802	3,477	2,913
98	3,403	3,600	4,619	1,847	3,564	2,986
99+	3,488	3,689	4,734	1,893	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 2/1/2019

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,450	1,535	1,969	788	1,519	1,119
66	1,450	1,535	1,969	788	1,519	1,150
67	1,450	1,535	1,969	788	1,519	1,180
68	1,468	1,553	1,993	798	1,537	1,226
69	1,500	1,587	2,035	815	1,571	1,284
70	1,540	1,629	2,088	836	1,612	1,351
71	1,587	1,677	2,151	861	1,660	1,391
72	1,635	1,729	2,220	887	1,713	1,434
73	1,688	1,786	2,291	916	1,768	1,482
74	1,747	1,849	2,371	949	1,830	1,533
75	1,810	1,916	2,458	983	1,897	1,590
76	1,876	1,983	2,544	1,017	1,964	1,644
77	1,938	2,051	2,631	1,052	2,030	1,701
78	2,001	2,116	2,717	1,086	2,096	1,757
79	2,067	2,186	2,806	1,121	2,164	1,813
80	2,133	2,254	2,894	1,157	2,232	1,871
81	2,200	2,326	2,984	1,194	2,303	1,930
82	2,267	2,398	3,078	1,231	2,375	1,990
83	2,337	2,472	3,172	1,269	2,448	2,051
84	2,409	2,547	3,270	1,308	2,522	2,114
85	2,493	2,636	3,384	1,352	2,610	2,187
86	2,564	2,712	3,481	1,393	2,686	2,249
87	2,638	2,789	3,578	1,432	2,762	2,314
88	2,711	2,869	3,678	1,472	2,839	2,378
89	2,787	2,947	3,781	1,512	2,919	2,444
90	2,862	3,028	3,886	1,554	2,998	2,513
91	2,940	3,110	3,991	1,597	3,081	2,580
92	3,021	3,194	4,098	1,640	3,163	2,649
93	3,101	3,280	4,208	1,683	3,247	2,722
94	3,183	3,366	4,320	1,728	3,333	2,792
95	3,266	3,455	4,431	1,772	3,420	2,864
96	3,350	3,544	4,545	1,819	3,508	2,940
97	3,436	3,634	4,662	1,866	3,598	3,015
98	3,522	3,726	4,781	1,912	3,689	3,091
99+	3,610	3,818	4,899	1,959	3,781	3,167

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,612	1,705	2,187	875	1,688	1,243
66	1,612	1,705	2,187	875	1,688	1,277
67	1,612	1,705	2,187	875	1,688	1,311
68	1,632	1,726	2,213	886	1,707	1,363
69	1,667	1,763	2,262	905	1,746	1,427
70	1,712	1,808	2,319	929	1,790	1,500
71	1,763	1,864	2,392	957	1,845	1,547
72	1,817	1,922	2,465	985	1,903	1,594
73	1,877	1,985	2,545	1,017	1,965	1,646
74	1,943	2,055	2,634	1,054	2,034	1,703
75	2,012	2,129	2,732	1,093	2,108	1,766
76	2,083	2,203	2,827	1,131	2,182	1,827
77	2,155	2,279	2,923	1,169	2,255	1,890
78	2,225	2,352	3,018	1,208	2,329	1,951
79	2,296	2,430	3,116	1,246	2,405	2,015
80	2,369	2,504	3,214	1,286	2,480	2,078
81	2,444	2,583	3,316	1,326	2,559	2,144
82	2,519	2,665	3,420	1,368	2,640	2,210
83	2,597	2,747	3,525	1,410	2,720	2,277
84	2,675	2,832	3,633	1,453	2,802	2,349
85	2,770	2,930	3,761	1,503	2,900	2,430
86	2,849	3,015	3,867	1,548	2,984	2,500
87	2,931	3,099	3,976	1,591	3,068	2,571
88	3,012	3,187	4,088	1,635	3,154	2,642
89	3,095	3,274	4,201	1,681	3,243	2,715
90	3,182	3,366	4,317	1,727	3,332	2,791
91	3,267	3,457	4,434	1,775	3,422	2,865
92	3,357	3,550	4,554	1,822	3,514	2,944
93	3,446	3,645	4,676	1,870	3,608	3,023
94	3,536	3,739	4,800	1,920	3,703	3,102
95	3,629	3,838	4,923	1,971	3,800	3,184
96	3,722	3,938	5,052	2,021	3,898	3,266
97	3,817	4,038	5,180	2,072	3,998	3,350
98	3,913	4,141	5,312	2,124	4,098	3,435
99+	4,011	4,242	5,445	2,177	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: Rest of State

Female Rates

Rates Effective 2/1/2019

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,201	1,271	1,631	652	1,258	926
66	1,201	1,271	1,631	652	1,258	952
67	1,201	1,271	1,631	652	1,258	977
68	1,216	1,286	1,650	661	1,273	1,016
69	1,243	1,313	1,685	675	1,301	1,064
70	1,275	1,348	1,730	692	1,335	1,119
71	1,313	1,389	1,782	713	1,375	1,152
72	1,354	1,432	1,838	735	1,418	1,188
73	1,398	1,479	1,898	759	1,464	1,226
74	1,448	1,531	1,964	786	1,516	1,270
75	1,500	1,587	2,036	814	1,571	1,317
76	1,553	1,643	2,107	843	1,626	1,362
77	1,606	1,698	2,179	871	1,681	1,409
78	1,658	1,753	2,250	899	1,736	1,454
79	1,711	1,810	2,323	929	1,792	1,502
80	1,766	1,867	2,396	958	1,849	1,549
81	1,821	1,926	2,471	989	1,907	1,598
82	1,878	1,986	2,548	1,019	1,967	1,648
83	1,936	2,047	2,627	1,051	2,027	1,698
84	1,995	2,110	2,708	1,083	2,089	1,750
85	2,064	2,183	2,802	1,121	2,162	1,811
86	2,123	2,246	2,882	1,153	2,224	1,863
87	2,184	2,310	2,964	1,186	2,287	1,916
88	2,245	2,375	3,047	1,219	2,351	1,970
89	2,308	2,441	3,132	1,252	2,417	2,024
90	2,371	2,508	3,218	1,287	2,483	2,080
91	2,435	2,576	3,305	1,322	2,551	2,136
92	2,502	2,645	3,394	1,358	2,619	2,194
93	2,568	2,716	3,485	1,394	2,689	2,253
94	2,636	2,787	3,577	1,431	2,760	2,312
95	2,704	2,860	3,670	1,468	2,832	2,372
96	2,774	2,934	3,765	1,506	2,905	2,434
97	2,845	3,009	3,861	1,545	2,980	2,496
98	2,917	3,086	3,959	1,584	3,055	2,560
99+	2,990	3,162	4,058	1,623	3,131	2,623

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,334	1,413	1,812	724	1,398	1,029
66	1,334	1,413	1,812	724	1,398	1,057
67	1,334	1,413	1,812	724	1,398	1,086
68	1,352	1,429	1,833	734	1,414	1,129
69	1,381	1,460	1,873	750	1,446	1,182
70	1,417	1,498	1,922	770	1,483	1,243
71	1,460	1,543	1,981	792	1,528	1,280
72	1,504	1,591	2,042	816	1,576	1,321
73	1,554	1,644	2,108	843	1,627	1,363
74	1,609	1,701	2,182	873	1,684	1,411
75	1,667	1,764	2,263	905	1,746	1,462
76	1,725	1,825	2,341	936	1,807	1,513
77	1,784	1,887	2,421	968	1,868	1,565
78	1,842	1,948	2,499	1,000	1,929	1,616
79	1,901	2,012	2,581	1,032	1,991	1,668
80	1,962	2,074	2,662	1,065	2,054	1,721
81	2,024	2,140	2,746	1,099	2,119	1,776
82	2,086	2,206	2,832	1,133	2,186	1,831
83	2,151	2,275	2,919	1,167	2,252	1,887
84	2,216	2,345	3,008	1,203	2,321	1,945
85	2,293	2,426	3,114	1,245	2,402	2,012
86	2,359	2,496	3,202	1,282	2,471	2,070
87	2,427	2,566	3,293	1,318	2,541	2,129
88	2,495	2,639	3,386	1,354	2,612	2,188
89	2,564	2,712	3,479	1,392	2,686	2,249
90	2,635	2,787	3,575	1,430	2,759	2,311
91	2,705	2,862	3,672	1,469	2,834	2,373
92	2,780	2,940	3,771	1,509	2,910	2,438
93	2,854	3,018	3,872	1,549	2,988	2,504
94	2,929	3,097	3,975	1,590	3,067	2,569
95	3,005	3,178	4,078	1,632	3,147	2,636
96	3,083	3,260	4,183	1,674	3,228	2,704
97	3,161	3,344	4,290	1,716	3,311	2,774
98	3,241	3,429	4,399	1,759	3,394	2,844
99+	3,322	3,513	4,509	1,803	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 2/1/2019

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,381	1,462	1,875	750	1,447	1,066
66	1,381	1,462	1,875	750	1,447	1,095
67	1,381	1,462	1,875	750	1,447	1,124
68	1,398	1,479	1,898	760	1,464	1,168
69	1,429	1,511	1,938	776	1,496	1,223
70	1,467	1,551	1,989	796	1,535	1,287
71	1,511	1,597	2,049	820	1,581	1,325
72	1,557	1,647	2,114	845	1,631	1,366
73	1,608	1,701	2,182	872	1,684	1,411
74	1,664	1,761	2,258	904	1,743	1,460
75	1,724	1,825	2,341	936	1,807	1,514
76	1,787	1,889	2,423	969	1,870	1,566
77	1,846	1,953	2,506	1,002	1,933	1,620
78	1,906	2,015	2,588	1,034	1,996	1,673
79	1,969	2,082	2,672	1,068	2,061	1,727
80	2,031	2,147	2,756	1,102	2,126	1,782
81	2,095	2,215	2,842	1,137	2,193	1,838
82	2,159	2,284	2,931	1,172	2,262	1,895
83	2,226	2,354	3,021	1,209	2,331	1,953
84	2,294	2,426	3,114	1,246	2,402	2,013
85	2,374	2,510	3,223	1,288	2,486	2,083
86	2,442	2,583	3,315	1,327	2,558	2,142
87	2,512	2,656	3,408	1,364	2,630	2,204
88	2,582	2,732	3,503	1,402	2,704	2,265
89	2,654	2,807	3,601	1,440	2,780	2,328
90	2,726	2,884	3,701	1,480	2,855	2,393
91	2,800	2,962	3,801	1,521	2,934	2,457
92	2,877	3,042	3,903	1,562	3,012	2,523
93	2,953	3,124	4,008	1,603	3,092	2,592
94	3,031	3,206	4,114	1,646	3,174	2,659
95	3,110	3,290	4,220	1,688	3,257	2,728
96	3,190	3,375	4,329	1,732	3,341	2,800
97	3,272	3,461	4,440	1,777	3,427	2,871
98	3,354	3,549	4,553	1,821	3,513	2,944
99+	3,438	3,636	4,666	1,866	3,601	3,016

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,535	1,624	2,083	833	1,608	1,184
66	1,535	1,624	2,083	833	1,608	1,216
67	1,535	1,624	2,083	833	1,608	1,249
68	1,554	1,644	2,108	844	1,626	1,298
69	1,588	1,679	2,154	862	1,663	1,359
70	1,630	1,722	2,209	885	1,705	1,429
71	1,679	1,775	2,278	911	1,757	1,473
72	1,730	1,830	2,348	938	1,812	1,518
73	1,788	1,890	2,424	969	1,871	1,568
74	1,850	1,957	2,509	1,004	1,937	1,622
75	1,916	2,028	2,602	1,041	2,008	1,682
76	1,984	2,098	2,692	1,077	2,078	1,740
77	2,052	2,170	2,784	1,113	2,148	1,800
78	2,119	2,240	2,874	1,150	2,218	1,858
79	2,187	2,314	2,968	1,187	2,290	1,919
80	2,256	2,385	3,061	1,225	2,362	1,979
81	2,328	2,460	3,158	1,263	2,437	2,042
82	2,399	2,538	3,257	1,303	2,514	2,105
83	2,473	2,616	3,357	1,343	2,590	2,169
84	2,548	2,697	3,460	1,384	2,669	2,237
85	2,638	2,790	3,582	1,431	2,762	2,314
86	2,713	2,871	3,683	1,474	2,842	2,381
87	2,791	2,951	3,787	1,515	2,922	2,449
88	2,869	3,035	3,893	1,557	3,004	2,516
89	2,948	3,118	4,001	1,601	3,089	2,586
90	3,030	3,206	4,111	1,645	3,173	2,658
91	3,111	3,292	4,223	1,690	3,259	2,729
92	3,197	3,381	4,337	1,735	3,347	2,804
93	3,282	3,471	4,453	1,781	3,436	2,879
94	3,368	3,561	4,571	1,829	3,527	2,954
95	3,456	3,655	4,689	1,877	3,619	3,032
96	3,545	3,750	4,811	1,925	3,712	3,110
97	3,635	3,846	4,933	1,973	3,808	3,190
98	3,727	3,944	5,059	2,023	3,903	3,271
99+	3,820	4,040	5,186	2,073	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 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 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 $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 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 $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 test, 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 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 $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 test, 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 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 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 $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 test, 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 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 $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 test, 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 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 $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 test, 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 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 $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 test, 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 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 $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