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

Outline of Coverage

Medicare Supplement Insurance

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

Insured by

An Aetna Company **Aetna Health Insurance Company**

Ohio

Rates Effective: 07/2017 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 $5120; paid at 100% after limit reached	Out-of-pocket limit $2560; 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 $2200 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2200. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Aetna Health Insurance Company

Annual Premiums

For Use in ZIP Codes: 450-454 and 459

Female Rates

Rates Effective 7/1/2017

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,157	1,224	1,571	628	1,321	1,069
66	1,157	1,224	1,571	628	1,321	1,069
67	1,157	1,224	1,571	628	1,321	1,069
68	1,172	1,239	1,590	636	1,337	1,083
69	1,197	1,265	1,623	650	1,366	1,106
70	1,229	1,299	1,666	667	1,402	1,135
71	1,265	1,338	1,717	687	1,444	1,169
72	1,304	1,380	1,770	708	1,489	1,205
73	1,347	1,425	1,828	731	1,537	1,244
74	1,394	1,475	1,892	757	1,592	1,288
75	1,445	1,529	1,961	784	1,650	1,336
76	1,496	1,582	2,030	812	1,707	1,382
77	1,547	1,636	2,099	839	1,765	1,429
78	1,597	1,688	2,167	866	1,823	1,475
79	1,649	1,744	2,238	895	1,882	1,524
80	1,701	1,799	2,308	923	1,941	1,572
81	1,755	1,855	2,380	952	2,002	1,621
82	1,809	1,913	2,455	982	2,065	1,672
83	1,865	1,972	2,531	1,012	2,128	1,723
84	1,922	2,033	2,608	1,044	2,193	1,776
85	1,989	2,103	2,700	1,079	2,270	1,838
86	2,045	2,164	2,776	1,111	2,335	1,890
87	2,104	2,225	2,855	1,142	2,401	1,944
88	2,163	2,288	2,935	1,174	2,469	1,998
89	2,223	2,351	3,017	1,206	2,538	2,054
90	2,284	2,416	3,100	1,240	2,607	2,111
91	2,346	2,481	3,184	1,274	2,679	2,167
92	2,410	2,548	3,270	1,308	2,750	2,226
93	2,474	2,617	3,357	1,343	2,823	2,286
94	2,539	2,685	3,446	1,379	2,898	2,346
95	2,605	2,755	3,535	1,414	2,974	2,407
96	2,672	2,827	3,627	1,451	3,050	2,470
97	2,741	2,899	3,719	1,488	3,129	2,533
98	2,810	2,973	3,814	1,526	3,208	2,597
99+	2,880	3,046	3,909	1,563	3,288	2,661

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,285	1,361	1,745	697	1,468	1,188
66	1,285	1,361	1,745	697	1,468	1,188
67	1,285	1,361	1,745	697	1,468	1,188
68	1,302	1,377	1,766	707	1,485	1,203
69	1,330	1,406	1,804	722	1,518	1,229
70	1,365	1,443	1,851	741	1,557	1,261
71	1,406	1,487	1,908	763	1,604	1,299
72	1,449	1,533	1,967	786	1,655	1,340
73	1,497	1,583	2,031	812	1,708	1,383
74	1,550	1,639	2,102	841	1,768	1,431
75	1,605	1,699	2,180	872	1,833	1,484
76	1,662	1,758	2,255	902	1,897	1,535
77	1,719	1,818	2,332	932	1,961	1,588
78	1,775	1,876	2,408	963	2,025	1,639
79	1,831	1,938	2,486	994	2,091	1,693
80	1,890	1,998	2,564	1,026	2,157	1,746
81	1,950	2,061	2,645	1,058	2,225	1,802
82	2,010	2,125	2,728	1,091	2,295	1,857
83	2,072	2,191	2,812	1,125	2,365	1,914
84	2,135	2,259	2,898	1,159	2,437	1,973
85	2,209	2,337	3,000	1,199	2,522	2,041
86	2,272	2,405	3,085	1,235	2,595	2,100
87	2,338	2,472	3,172	1,269	2,668	2,160
88	2,403	2,542	3,261	1,304	2,743	2,220
89	2,470	2,612	3,352	1,341	2,820	2,282
90	2,538	2,685	3,444	1,378	2,897	2,345
91	2,606	2,757	3,537	1,415	2,976	2,408
92	2,678	2,832	3,633	1,453	3,056	2,474
93	2,749	2,907	3,730	1,492	3,137	2,540
94	2,821	2,983	3,829	1,532	3,220	2,606
95	2,895	3,062	3,928	1,572	3,304	2,674
96	2,969	3,141	4,030	1,613	3,389	2,744
97	3,045	3,221	4,133	1,653	3,477	2,814
98	3,122	3,303	4,238	1,695	3,564	2,885
99+	3,200	3,384	4,344	1,737	3,653	2,957

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 7/1/2017

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,330	1,408	1,806	722	1,519	1,230
66	1,330	1,408	1,806	722	1,519	1,230
67	1,330	1,408	1,806	722	1,519	1,230
68	1,347	1,425	1,828	732	1,537	1,245
69	1,377	1,455	1,867	748	1,571	1,272
70	1,413	1,494	1,916	767	1,612	1,305
71	1,455	1,538	1,974	790	1,660	1,344
72	1,499	1,587	2,036	814	1,713	1,386
73	1,549	1,639	2,102	840	1,768	1,431
74	1,603	1,697	2,176	870	1,830	1,482
75	1,661	1,758	2,255	902	1,897	1,536
76	1,721	1,820	2,334	933	1,964	1,589
77	1,779	1,882	2,414	965	2,030	1,643
78	1,836	1,941	2,493	996	2,096	1,697
79	1,896	2,006	2,574	1,029	2,164	1,752
80	1,956	2,069	2,654	1,062	2,232	1,808
81	2,018	2,134	2,737	1,095	2,303	1,865
82	2,080	2,200	2,823	1,129	2,375	1,923
83	2,144	2,268	2,911	1,164	2,448	1,981
84	2,210	2,337	3,000	1,200	2,522	2,042
85	2,287	2,418	3,105	1,241	2,610	2,114
86	2,352	2,489	3,193	1,278	2,686	2,174
87	2,420	2,559	3,283	1,314	2,762	2,235
88	2,487	2,631	3,375	1,350	2,839	2,297
89	2,557	2,704	3,469	1,387	2,919	2,361
90	2,626	2,778	3,565	1,426	2,998	2,428
91	2,697	2,853	3,661	1,465	3,081	2,493
92	2,771	2,931	3,760	1,505	3,163	2,560
93	2,844	3,009	3,861	1,545	3,247	2,629
94	2,920	3,088	3,963	1,586	3,333	2,697
95	2,996	3,169	4,066	1,626	3,420	2,768
96	3,073	3,251	4,171	1,668	3,508	2,840
97	3,152	3,334	4,277	1,712	3,598	2,913
98	3,231	3,419	4,386	1,755	3,689	2,986
99+	3,312	3,503	4,495	1,798	3,781	3,060

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,478	1,565	2,007	802	1,688	1,366
66	1,478	1,565	2,007	802	1,688	1,366
67	1,478	1,565	2,007	802	1,688	1,366
68	1,497	1,583	2,031	813	1,707	1,384
69	1,530	1,617	2,075	831	1,746	1,413
70	1,570	1,659	2,128	853	1,790	1,450
71	1,617	1,709	2,195	878	1,845	1,494
72	1,666	1,763	2,262	904	1,903	1,540
73	1,722	1,821	2,335	933	1,965	1,591
74	1,782	1,885	2,417	967	2,034	1,645
75	1,846	1,954	2,506	1,003	2,108	1,706
76	1,911	2,021	2,594	1,037	2,182	1,765
77	1,977	2,091	2,682	1,072	2,255	1,826
78	2,041	2,158	2,769	1,108	2,329	1,885
79	2,106	2,229	2,859	1,143	2,405	1,947
80	2,174	2,297	2,948	1,180	2,480	2,008
81	2,243	2,370	3,042	1,217	2,559	2,072
82	2,311	2,444	3,137	1,255	2,640	2,136
83	2,382	2,520	3,234	1,294	2,720	2,201
84	2,455	2,598	3,333	1,334	2,802	2,269
85	2,541	2,688	3,450	1,379	2,900	2,348
86	2,613	2,766	3,548	1,420	2,984	2,415
87	2,689	2,842	3,648	1,460	3,068	2,484
88	2,764	2,923	3,751	1,499	3,154	2,553
89	2,840	3,004	3,855	1,542	3,243	2,624
90	2,919	3,088	3,961	1,584	3,332	2,696
91	2,997	3,171	4,068	1,628	3,422	2,769
92	3,080	3,257	4,178	1,672	3,514	2,844
93	3,162	3,343	4,289	1,716	3,608	2,921
94	3,245	3,430	4,404	1,762	3,703	2,997
95	3,330	3,521	4,517	1,808	3,800	3,075
96	3,415	3,612	4,635	1,854	3,898	3,155
97	3,502	3,704	4,752	1,901	3,998	3,236
98	3,590	3,799	4,873	1,949	4,098	3,318
99+	3,680	3,891	4,996	1,997	4,201	3,400

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

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

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Aetna Health Insurance Company

Annual Premiums

For Use in ZIP Codes: 436 and 440-445

Female Rates

Rates Effective 7/1/2017

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,289	1,364	1,750	700	1,472	1,191
66	1,289	1,364	1,750	700	1,472	1,191
67	1,289	1,364	1,750	700	1,472	1,191
68	1,306	1,381	1,771	709	1,489	1,206
69	1,334	1,410	1,809	724	1,522	1,232
70	1,369	1,447	1,857	743	1,562	1,265
71	1,410	1,491	1,913	765	1,609	1,302
72	1,453	1,537	1,973	789	1,659	1,343
73	1,501	1,588	2,037	814	1,713	1,386
74	1,554	1,644	2,108	844	1,774	1,436
75	1,610	1,704	2,186	874	1,838	1,488
76	1,667	1,763	2,262	904	1,902	1,540
77	1,723	1,823	2,339	935	1,967	1,592
78	1,780	1,881	2,415	965	2,031	1,644
79	1,837	1,943	2,493	997	2,097	1,698
80	1,895	2,004	2,572	1,028	2,163	1,751
81	1,955	2,067	2,652	1,061	2,231	1,806
82	2,016	2,132	2,735	1,094	2,301	1,863
83	2,078	2,197	2,820	1,128	2,372	1,920
84	2,141	2,265	2,906	1,163	2,444	1,978
85	2,216	2,344	3,008	1,203	2,530	2,048
86	2,279	2,411	3,093	1,238	2,602	2,106
87	2,345	2,479	3,181	1,273	2,676	2,166
88	2,410	2,549	3,270	1,308	2,751	2,227
89	2,477	2,620	3,361	1,344	2,828	2,289
90	2,545	2,692	3,454	1,382	2,905	2,352
91	2,614	2,765	3,547	1,419	2,985	2,415
92	2,685	2,840	3,643	1,458	3,064	2,480
93	2,757	2,916	3,740	1,496	3,146	2,547
94	2,829	2,992	3,840	1,536	3,229	2,614
95	2,903	3,070	3,939	1,576	3,313	2,682
96	2,978	3,150	4,041	1,617	3,399	2,752
97	3,054	3,230	4,144	1,658	3,487	2,822
98	3,131	3,312	4,249	1,700	3,574	2,893
99+	3,209	3,394	4,356	1,742	3,663	2,965

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,432	1,516	1,945	777	1,636	1,323
66	1,432	1,516	1,945	777	1,636	1,323
67	1,432	1,516	1,945	777	1,636	1,323
68	1,451	1,534	1,968	787	1,654	1,341
69	1,482	1,567	2,010	805	1,692	1,369
70	1,521	1,608	2,063	826	1,735	1,405
71	1,567	1,657	2,126	851	1,788	1,447
72	1,615	1,708	2,191	876	1,844	1,493
73	1,668	1,764	2,263	904	1,904	1,541
74	1,727	1,826	2,342	937	1,970	1,595
75	1,789	1,893	2,429	971	2,043	1,653
76	1,852	1,959	2,513	1,005	2,114	1,711
77	1,915	2,025	2,599	1,039	2,186	1,769
78	1,977	2,091	2,683	1,073	2,257	1,826
79	2,040	2,160	2,771	1,108	2,329	1,886
80	2,106	2,227	2,857	1,143	2,403	1,946
81	2,173	2,297	2,947	1,179	2,479	2,008
82	2,239	2,368	3,040	1,216	2,558	2,070
83	2,308	2,442	3,133	1,253	2,635	2,133
84	2,379	2,517	3,229	1,292	2,716	2,198
85	2,462	2,604	3,343	1,336	2,810	2,274
86	2,532	2,679	3,437	1,376	2,891	2,340
87	2,606	2,754	3,535	1,415	2,973	2,407
88	2,678	2,833	3,634	1,453	3,056	2,473
89	2,752	2,911	3,735	1,494	3,143	2,542
90	2,828	2,992	3,838	1,535	3,228	2,613
91	2,904	3,072	3,942	1,577	3,316	2,683
92	2,984	3,155	4,048	1,619	3,405	2,757
93	3,063	3,240	4,156	1,663	3,496	2,830
94	3,144	3,324	4,267	1,707	3,588	2,904
95	3,226	3,412	4,377	1,751	3,682	2,980
96	3,309	3,499	4,490	1,797	3,777	3,057
97	3,393	3,590	4,605	1,842	3,874	3,136
98	3,478	3,681	4,722	1,888	3,971	3,215
99+	3,566	3,771	4,840	1,935	4,070	3,295

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 7/1/2017

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,482	1,569	2,012	805	1,693	1,370
66	1,482	1,569	2,012	805	1,693	1,370
67	1,482	1,569	2,012	805	1,693	1,370
68	1,501	1,588	2,037	815	1,713	1,388
69	1,534	1,622	2,080	833	1,750	1,417
70	1,575	1,665	2,135	854	1,796	1,454
71	1,622	1,714	2,200	880	1,850	1,498
72	1,671	1,768	2,269	907	1,908	1,544
73	1,726	1,826	2,342	936	1,970	1,595
74	1,787	1,891	2,424	970	2,039	1,651
75	1,851	1,959	2,513	1,005	2,114	1,712
76	1,918	2,028	2,601	1,040	2,188	1,770
77	1,982	2,097	2,690	1,075	2,262	1,831
78	2,046	2,163	2,778	1,110	2,335	1,891
79	2,113	2,235	2,868	1,147	2,411	1,953
80	2,180	2,305	2,958	1,183	2,487	2,015
81	2,249	2,377	3,050	1,220	2,566	2,078
82	2,318	2,451	3,146	1,258	2,647	2,142
83	2,389	2,527	3,243	1,298	2,727	2,208
84	2,463	2,604	3,343	1,337	2,810	2,276
85	2,548	2,695	3,460	1,383	2,909	2,355
86	2,621	2,773	3,558	1,424	2,993	2,422
87	2,697	2,851	3,659	1,464	3,077	2,491
88	2,772	2,932	3,760	1,505	3,164	2,560
89	2,849	3,013	3,866	1,546	3,253	2,631
90	2,926	3,096	3,972	1,589	3,340	2,705
91	3,006	3,179	4,080	1,632	3,433	2,778
92	3,088	3,265	4,190	1,677	3,524	2,852
93	3,170	3,353	4,302	1,721	3,618	2,930
94	3,254	3,441	4,416	1,767	3,714	3,006
95	3,338	3,531	4,530	1,812	3,811	3,084
96	3,425	3,622	4,647	1,859	3,909	3,165
97	3,512	3,715	4,765	1,907	4,010	3,246
98	3,600	3,810	4,887	1,955	4,110	3,327
99+	3,690	3,903	5,009	2,003	4,213	3,409

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,647	1,743	2,236	894	1,881	1,522
66	1,647	1,743	2,236	894	1,881	1,522
67	1,647	1,743	2,236	894	1,881	1,522
68	1,668	1,764	2,263	906	1,902	1,542
69	1,705	1,802	2,312	925	1,946	1,575
70	1,749	1,849	2,372	950	1,995	1,616
71	1,802	1,905	2,445	978	2,056	1,665
72	1,857	1,964	2,520	1,007	2,120	1,716
73	1,919	2,029	2,602	1,040	2,189	1,773
74	1,985	2,100	2,693	1,078	2,266	1,833
75	2,057	2,177	2,793	1,117	2,349	1,901
76	2,129	2,252	2,890	1,156	2,431	1,967
77	2,203	2,329	2,988	1,195	2,513	2,035
78	2,274	2,404	3,085	1,234	2,595	2,100
79	2,347	2,484	3,186	1,274	2,679	2,169
80	2,422	2,560	3,285	1,315	2,764	2,237
81	2,499	2,641	3,389	1,356	2,851	2,308
82	2,575	2,724	3,496	1,398	2,941	2,380
83	2,655	2,808	3,604	1,441	3,030	2,452
84	2,735	2,895	3,714	1,486	3,123	2,528
85	2,831	2,995	3,845	1,536	3,232	2,616
86	2,912	3,082	3,953	1,582	3,325	2,691
87	2,996	3,167	4,065	1,626	3,419	2,768
88	3,079	3,257	4,179	1,671	3,515	2,844
89	3,165	3,347	4,295	1,719	3,614	2,924
90	3,253	3,441	4,413	1,766	3,712	3,005
91	3,339	3,533	4,533	1,814	3,813	3,085
92	3,432	3,629	4,655	1,863	3,916	3,170
93	3,523	3,725	4,779	1,912	4,020	3,255
94	3,615	3,822	4,907	1,963	4,127	3,339
95	3,710	3,923	5,033	2,015	4,234	3,427
96	3,805	4,025	5,164	2,066	4,343	3,516
97	3,902	4,128	5,295	2,118	4,455	3,606
98	4,000	4,233	5,430	2,172	4,567	3,697
99+	4,101	4,336	5,567	2,225	4,681	3,788

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 7/1/2017

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,102	1,166	1,496	598	1,258	1,018
66	1,102	1,166	1,496	598	1,258	1,018
67	1,102	1,166	1,496	598	1,258	1,018
68	1,116	1,180	1,514	606	1,273	1,031
69	1,140	1,205	1,546	619	1,301	1,053
70	1,170	1,237	1,587	635	1,335	1,081
71	1,205	1,274	1,635	654	1,375	1,113
72	1,242	1,314	1,686	674	1,418	1,148
73	1,283	1,357	1,741	696	1,464	1,185
74	1,328	1,405	1,802	721	1,516	1,227
75	1,376	1,456	1,868	747	1,571	1,272
76	1,425	1,507	1,933	773	1,626	1,316
77	1,473	1,558	1,999	799	1,681	1,361
78	1,521	1,608	2,064	825	1,736	1,405
79	1,570	1,661	2,131	852	1,792	1,451
80	1,620	1,713	2,198	879	1,849	1,497
81	1,671	1,767	2,267	907	1,907	1,544
82	1,723	1,822	2,338	935	1,967	1,592
83	1,776	1,878	2,410	964	2,027	1,641
84	1,830	1,936	2,484	994	2,089	1,691
85	1,894	2,003	2,571	1,028	2,162	1,750
86	1,948	2,061	2,644	1,058	2,224	1,800
87	2,004	2,119	2,719	1,088	2,287	1,851
88	2,060	2,179	2,795	1,118	2,351	1,903
89	2,117	2,239	2,873	1,149	2,417	1,956
90	2,175	2,301	2,952	1,181	2,483	2,010
91	2,234	2,363	3,032	1,213	2,551	2,064
92	2,295	2,427	3,114	1,246	2,619	2,120
93	2,356	2,492	3,197	1,279	2,689	2,177
94	2,418	2,557	3,282	1,313	2,760	2,234
95	2,481	2,624	3,367	1,347	2,832	2,292
96	2,545	2,692	3,454	1,382	2,905	2,352
97	2,610	2,761	3,542	1,417	2,980	2,412
98	2,676	2,831	3,632	1,453	3,055	2,473
99+	2,743	2,901	3,723	1,489	3,131	2,534

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,224	1,296	1,662	664	1,398	1,131
66	1,224	1,296	1,662	664	1,398	1,131
67	1,224	1,296	1,662	664	1,398	1,131
68	1,240	1,311	1,682	673	1,414	1,146
69	1,267	1,339	1,718	688	1,446	1,170
70	1,300	1,374	1,763	706	1,483	1,201
71	1,339	1,416	1,817	727	1,528	1,237
72	1,380	1,460	1,873	749	1,576	1,276
73	1,426	1,508	1,934	773	1,627	1,317
74	1,476	1,561	2,002	801	1,684	1,363
75	1,529	1,618	2,076	830	1,746	1,413
76	1,583	1,674	2,148	859	1,807	1,462
77	1,637	1,731	2,221	888	1,868	1,512
78	1,690	1,787	2,293	917	1,929	1,561
79	1,744	1,846	2,368	947	1,991	1,612
80	1,800	1,903	2,442	977	2,054	1,663
81	1,857	1,963	2,519	1,008	2,119	1,716
82	1,914	2,024	2,598	1,039	2,186	1,769
83	1,973	2,087	2,678	1,071	2,252	1,823
84	2,033	2,151	2,760	1,104	2,321	1,879
85	2,104	2,226	2,857	1,142	2,402	1,944
86	2,164	2,290	2,938	1,176	2,471	2,000
87	2,227	2,354	3,021	1,209	2,541	2,057
88	2,289	2,421	3,106	1,242	2,612	2,114
89	2,352	2,488	3,192	1,277	2,686	2,173
90	2,417	2,557	3,280	1,312	2,759	2,233
91	2,482	2,626	3,369	1,348	2,834	2,293
92	2,550	2,697	3,460	1,384	2,910	2,356
93	2,618	2,769	3,552	1,421	2,988	2,419
94	2,687	2,841	3,647	1,459	3,067	2,482
95	2,757	2,916	3,741	1,497	3,147	2,547
96	2,828	2,991	3,838	1,536	3,228	2,613
97	2,900	3,068	3,936	1,574	3,311	2,680
98	2,973	3,146	4,036	1,614	3,394	2,748
99+	3,048	3,223	4,137	1,654	3,479	2,816

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 7/1/2017

Attained Age	Preferred						Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,267	1,341	1,720	688	1,447	1,171	1,408	1,490	1,911	764	1,608	1,301
66	1,267	1,341	1,720	688	1,447	1,171	1,408	1,490	1,911	764	1,608	1,301
67	1,267	1,341	1,720	688	1,447	1,171	1,408	1,490	1,911	764	1,608	1,301
68	1,283	1,357	1,741	697	1,464	1,186	1,426	1,508	1,934	774	1,626	1,318
69	1,311	1,386	1,778	712	1,496	1,211	1,457	1,540	1,976	791	1,663	1,346
70	1,346	1,423	1,825	730	1,535	1,243	1,495	1,580	2,027	812	1,705	1,381
71	1,386	1,465	1,880	752	1,581	1,280	1,540	1,628	2,090	836	1,757	1,423
72	1,428	1,511	1,939	775	1,631	1,320	1,587	1,679	2,154	861	1,812	1,467
73	1,475	1,561	2,002	800	1,684	1,363	1,640	1,734	2,224	889	1,871	1,515
74	1,527	1,616	2,072	829	1,743	1,411	1,697	1,795	2,302	921	1,937	1,567
75	1,582	1,674	2,148	859	1,807	1,463	1,758	1,861	2,387	955	2,008	1,625
76	1,639	1,733	2,223	889	1,870	1,513	1,820	1,925	2,470	988	2,078	1,681
77	1,694	1,792	2,299	919	1,933	1,565	1,883	1,991	2,554	1,021	2,148	1,739
78	1,749	1,849	2,374	949	1,996	1,616	1,944	2,055	2,637	1,055	2,218	1,795
79	1,806	1,910	2,451	980	2,061	1,669	2,006	2,123	2,723	1,089	2,290	1,854
80	1,863	1,970	2,528	1,011	2,126	1,722	2,070	2,188	2,808	1,124	2,362	1,912
81	1,922	2,032	2,607	1,043	2,193	1,776	2,136	2,257	2,897	1,159	2,437	1,973
82	1,981	2,095	2,689	1,075	2,262	1,831	2,201	2,328	2,988	1,195	2,514	2,034
83	2,042	2,160	2,772	1,109	2,331	1,887	2,269	2,400	3,080	1,232	2,590	2,096
84	2,105	2,226	2,857	1,143	2,402	1,945	2,338	2,474	3,174	1,270	2,669	2,161
85	2,178	2,303	2,957	1,182	2,486	2,013	2,420	2,560	3,286	1,313	2,762	2,236
86	2,240	2,370	3,041	1,217	2,558	2,070	2,489	2,634	3,379	1,352	2,842	2,300
87	2,305	2,437	3,127	1,251	2,630	2,129	2,561	2,707	3,474	1,390	2,922	2,366
88	2,369	2,506	3,214	1,286	2,704	2,188	2,632	2,784	3,572	1,428	3,004	2,431
89	2,435	2,575	3,304	1,321	2,780	2,249	2,705	2,861	3,671	1,469	3,089	2,499
90	2,501	2,646	3,395	1,358	2,855	2,312	2,780	2,941	3,772	1,509	3,173	2,568
91	2,569	2,717	3,487	1,395	2,934	2,374	2,854	3,020	3,874	1,550	3,259	2,637
92	2,639	2,791	3,581	1,433	3,012	2,438	2,933	3,102	3,979	1,592	3,347	2,709
93	2,709	2,866	3,677	1,471	3,092	2,504	3,011	3,184	4,085	1,634	3,436	2,782
94	2,781	2,941	3,774	1,510	3,174	2,569	3,090	3,267	4,194	1,678	3,527	2,854
95	2,853	3,018	3,872	1,549	3,257	2,636	3,171	3,353	4,302	1,722	3,619	2,929
96	2,927	3,096	3,972	1,589	3,341	2,705	3,252	3,440	4,414	1,766	3,712	3,005
97	3,002	3,175	4,073	1,630	3,427	2,774	3,335	3,528	4,526	1,810	3,808	3,082
98	3,077	3,256	4,177	1,671	3,513	2,844	3,419	3,618	4,641	1,856	3,903	3,160
99+	3,154	3,336	4,281	1,712	3,601	2,914	3,505	3,706	4,758	1,902	4,001	3,238

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 $1316	$0	$1316 (Part A Deductible)
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	$0	Up to $164.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

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

PLAN A

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

*Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $183 of Medicare-Approved amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $183 of Medicare-Approved amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $183 of Medicare Approved amounts*	$0	$0	$183 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1316	$1316 (Part A Deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	$0	Up to $164.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

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

PLAN B

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

* Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $183 of Medicare-Approved amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $183 of Medicare-Approved amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $183 of Medicare Approved amounts*	$0	$0	$183 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1316	$1316 (Part A Deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

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

PLAN F

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

*Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $183 of Medicare-Approved amounts*	$0	$183 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $183 of Medicare-Approved amounts*	$0	$183 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $183 of Medicare Approved amounts*	$0	$183 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE PLAN F

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

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

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2200 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2200. 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 $2200 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2200 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1316	$1316 (Part A Deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

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

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2200 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2200. 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 $2200 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2200 DEDUCTIBLE*** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $183 of Medicare-Approved amounts*	$0	$183 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $183 of Medicare-Approved amounts*	$0	$183 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2200 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2200 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $183 of Medicare Approved amounts*	$0	$183 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2200 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2200 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 $1316	$1316 (Part A Deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

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

PLAN G

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

*Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $183 of Medicare-Approved amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $183 of Medicare-Approved amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $183 of Medicare Approved amounts*	$0	$0	$183 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

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 $1316	$1316 (Part A Deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

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

PLAN N

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

*Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $183 of Medicare-Approved amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-Approved amounts)	$0	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $183 of Medicare-Approved amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment •First $183 of Medicare Approved amounts*	$0	$0	$183 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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