Outline of coverage

Medicare Supplement Insurance

Benefit Plans A, B, F, High Deductible F, G, N

Texas

Underwritten by

Aetna Health Insurance Company

AetnaSeniorProducts.com

AHCMS05279TX

Rates effective: 02/2024 A

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

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F. Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2024[2]					**$7,060[2]**	**$3,530[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,800** before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

Aetna Health Insurance Company
Annual premiums
For use in ZIP Codes: 770, 772-773, 775
Female rates

Rates effective 2/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	8,671	n/a	n/a	n/a	n/a	n/a
65	2,053	2,106	3,011	657	2,373	1,629
66	2,053	2,106	3,011	657	2,373	1,629
67	2,053	2,106	3,011	657	2,373	1,629
68	2,074	2,128	3,043	663	2,397	1,687
69	2,123	2,178	3,113	681	2,455	1,755
70	2,176	2,235	3,196	697	2,518	1,824
71	2,240	2,301	3,294	718	2,592	1,888
72	2,314	2,372	3,394	740	2,675	1,952
73	2,387	2,452	3,505	765	2,763	2,017
74	2,474	2,537	3,627	792	2,860	2,086
75	2,559	2,628	3,756	820	2,960	2,153
76	2,649	2,718	3,886	847	3,062	2,222
77	2,742	2,813	4,023	876	3,170	2,295
78	2,835	2,908	4,159	907	3,278	2,373
79	2,923	3,002	4,288	935	3,379	2,448
80	3,015	3,094	4,426	966	3,489	2,530
81	3,109	3,191	4,563	997	3,597	2,610
82	3,200	3,288	4,698	1,024	3,705	2,688
83	3,303	3,390	4,845	1,057	3,818	2,771
84	3,400	3,487	4,986	1,087	3,930	2,853
85	3,520	3,614	5,166	1,127	4,072	2,956
86	3,625	3,717	5,312	1,159	4,189	3,040
87	3,725	3,824	5,465	1,193	4,308	3,125
88	3,828	3,929	5,619	1,226	4,427	3,213
89	3,934	4,037	5,773	1,261	4,549	3,304
90	4,047	4,151	5,935	1,294	4,677	3,393
91	4,154	4,263	6,096	1,331	4,804	3,487
92	4,265	4,379	6,256	1,365	4,933	3,579
93	4,378	4,494	6,424	1,403	5,063	3,677
94	4,494	4,614	6,597	1,439	5,201	3,773
95	4,614	4,734	6,766	1,477	5,335	3,871
96	4,732	4,856	6,943	1,514	5,471	3,972
97	4,852	4,981	7,119	1,554	5,612	4,072
98	4,975	5,107	7,296	1,593	5,754	4,174
99+	5,100	5,231	7,481	1,633	5,896	4,279

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	9,633	n/a	n/a	n/a	n/a	n/a
65	2,282	2,340	3,346	729	2,637	1,810
66	2,282	2,340	3,346	729	2,637	1,810
67	2,282	2,340	3,346	729	2,637	1,810
68	2,303	2,366	3,381	737	2,664	1,875
69	2,357	2,421	3,456	756	2,728	1,952
70	2,417	2,483	3,551	773	2,795	2,025
71	2,492	2,558	3,656	797	2,880	2,096
72	2,567	2,638	3,769	824	2,975	2,167
73	2,653	2,724	3,894	850	3,069	2,243
74	2,750	2,819	4,029	879	3,176	2,318
75	2,842	2,919	4,171	910	3,288	2,392
76	2,944	3,022	4,317	941	3,402	2,470
77	3,047	3,125	4,470	976	3,523	2,549
78	3,150	3,231	4,622	1,008	3,639	2,634
79	3,247	3,337	4,766	1,040	3,756	2,719
80	3,350	3,437	4,916	1,072	3,874	2,814
81	3,455	3,544	5,073	1,108	3,999	2,901
82	3,560	3,652	5,221	1,139	4,116	2,987
83	3,668	3,764	5,381	1,177	4,242	3,079
84	3,775	3,874	5,538	1,209	4,370	3,169
85	3,911	4,015	5,741	1,253	4,524	3,284
86	4,024	4,127	5,903	1,289	4,655	3,378
87	4,139	4,249	6,073	1,325	4,786	3,473
88	4,253	4,366	6,243	1,363	4,920	3,571
89	4,372	4,486	6,417	1,402	5,054	3,670
90	4,493	4,612	6,593	1,438	5,195	3,772
91	4,615	4,737	6,772	1,478	5,336	3,875
92	4,737	4,864	6,956	1,518	5,479	3,980
93	4,864	4,994	7,137	1,560	5,628	4,084
94	4,996	5,126	7,331	1,601	5,777	4,192
95	5,126	5,260	7,520	1,640	5,928	4,301
96	5,257	5,395	7,713	1,683	6,081	4,413
97	5,389	5,533	7,909	1,726	6,238	4,524
98	5,529	5,674	8,108	1,771	6,390	4,639
99+	5,664	5,816	8,312	1,816	6,553	4,754

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 periods, use preferred rates.

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

Aetna Health Insurance Company
Annual premiums
For use in ZIP Codes: 770, 772-773, 775
Male rates

Rates effective 2/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	9,972	n/a	n/a	n/a	n/a	n/a
65	2,361	2,423	3,463	756	2,730	1,875
66	2,361	2,423	3,463	756	2,730	1,875
67	2,361	2,423	3,463	756	2,730	1,875
68	2,384	2,448	3,499	764	2,759	1,938
69	2,437	2,502	3,579	781	2,821	2,018
70	2,503	2,569	3,674	801	2,894	2,096
71	2,580	2,647	3,784	827	2,980	2,171
72	2,661	2,728	3,906	851	3,075	2,245
73	2,744	2,819	4,031	879	3,176	2,320
74	2,843	2,919	4,171	911	3,288	2,400
75	2,944	3,022	4,319	941	3,402	2,478
76	3,047	3,126	4,469	974	3,522	2,555
77	3,152	3,232	4,626	1,009	3,649	2,641
78	3,260	3,346	4,784	1,044	3,769	2,730
79	3,362	3,452	4,934	1,076	3,886	2,817
80	3,465	3,558	5,087	1,111	4,009	2,910
81	3,578	3,672	5,249	1,146	4,138	3,002
82	3,684	3,780	5,403	1,179	4,261	3,091
83	3,796	3,897	5,569	1,217	4,389	3,187
84	3,906	4,012	5,734	1,252	4,520	3,280
85	4,049	4,155	5,940	1,296	4,683	3,398
86	4,167	4,277	6,112	1,333	4,817	3,496
87	4,284	4,394	6,287	1,371	4,955	3,595
88	4,403	4,517	6,460	1,410	5,089	3,697
89	4,525	4,644	6,640	1,450	5,233	3,800
90	4,651	4,772	6,822	1,490	5,379	3,902
91	4,776	4,903	7,008	1,530	5,525	4,009
92	4,906	5,034	7,194	1,570	5,670	4,119
93	5,037	5,171	7,387	1,613	5,824	4,228
94	5,171	5,305	7,583	1,656	5,980	4,338
95	5,302	5,443	7,780	1,699	6,136	4,451
96	5,443	5,584	7,984	1,743	6,294	4,567
97	5,581	5,727	8,186	1,786	6,453	4,682
98	5,722	5,871	8,391	1,833	6,616	4,803
99+	5,865	6,018	8,605	1,877	6,783	4,922

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	11,080	n/a	n/a	n/a	n/a	n/a
65	2,624	2,691	3,844	839	3,034	2,082
66	2,624	2,691	3,844	839	3,034	2,082
67	2,624	2,691	3,844	839	3,034	2,082
68	2,649	2,723	3,887	848	3,067	2,153
69	2,711	2,785	3,976	868	3,137	2,245
70	2,782	2,854	4,082	891	3,216	2,330
71	2,865	2,940	4,205	917	3,311	2,412
72	2,953	3,032	4,339	946	3,420	2,492
73	3,050	3,132	4,477	978	3,526	2,577
74	3,158	3,244	4,634	1,012	3,654	2,667
75	3,270	3,357	4,799	1,047	3,780	2,751
76	3,385	3,473	4,962	1,081	3,914	2,839
77	3,504	3,591	5,140	1,122	4,051	2,932
78	3,625	3,717	5,313	1,158	4,188	3,032
79	3,735	3,834	5,482	1,195	4,317	3,129
80	3,851	3,950	5,656	1,231	4,456	3,235
81	3,974	4,079	5,832	1,274	4,599	3,338
82	4,092	4,198	6,002	1,309	4,733	3,436
83	4,217	4,330	6,191	1,352	4,879	3,542
84	4,342	4,457	6,370	1,391	5,024	3,645
85	4,500	4,616	6,604	1,439	5,202	3,777
86	4,631	4,749	6,790	1,483	5,353	3,886
87	4,760	4,884	6,984	1,524	5,506	3,995
88	4,894	5,020	7,178	1,568	5,657	4,107
89	5,026	5,160	7,377	1,612	5,814	4,221
90	5,170	5,304	7,580	1,654	5,972	4,336
91	5,306	5,450	7,789	1,700	6,137	4,457
92	5,451	5,593	7,998	1,746	6,299	4,576
93	5,596	5,743	8,209	1,793	6,471	4,695
94	5,743	5,895	8,426	1,841	6,644	4,820
95	5,892	6,046	8,646	1,887	6,818	4,947
96	6,046	6,206	8,869	1,936	6,992	5,076
97	6,199	6,362	9,099	1,985	7,173	5,203
98	6,356	6,526	9,325	2,037	7,353	5,336
99+	6,516	6,687	9,558	2,088	7,533	5,467

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 periods, use preferred rates.

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

Aetna Health Insurance Company

Annual premiums

For Use in ZIP Codes: 750-752, 760-761, 774, 776-777, 782, 784, 793-794

Female rates

Rates effective 2/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	7,118	n/a	n/a	n/a	n/a	n/a
65	1,685	1,729	2,472	539	1,948	1,338
66	1,685	1,729	2,472	539	1,948	1,338
67	1,685	1,729	2,472	539	1,948	1,338
68	1,703	1,747	2,498	545	1,968	1,385
69	1,742	1,788	2,555	559	2,015	1,441
70	1,786	1,835	2,624	572	2,067	1,497
71	1,839	1,889	2,704	590	2,127	1,550
72	1,900	1,947	2,786	607	2,196	1,603
73	1,959	2,013	2,878	628	2,268	1,656
74	2,031	2,082	2,978	650	2,347	1,713
75	2,101	2,157	3,083	673	2,430	1,768
76	2,175	2,231	3,190	695	2,514	1,824
77	2,251	2,309	3,302	719	2,603	1,884
78	2,328	2,387	3,414	745	2,691	1,948
79	2,399	2,464	3,520	768	2,774	2,010
80	2,475	2,540	3,633	793	2,864	2,077
81	2,552	2,619	3,746	818	2,952	2,143
82	2,627	2,699	3,857	840	3,042	2,207
83	2,712	2,783	3,978	868	3,134	2,275
84	2,791	2,862	4,093	892	3,226	2,342
85	2,890	2,967	4,241	925	3,343	2,427
86	2,976	3,051	4,360	952	3,439	2,496
87	3,058	3,139	4,486	979	3,537	2,565
88	3,143	3,225	4,612	1,007	3,634	2,638
89	3,230	3,314	4,739	1,035	3,735	2,713
90	3,322	3,408	4,872	1,063	3,839	2,785
91	3,410	3,499	5,004	1,092	3,944	2,862
92	3,501	3,595	5,136	1,121	4,049	2,938
93	3,594	3,689	5,273	1,152	4,156	3,018
94	3,689	3,787	5,415	1,181	4,269	3,098
95	3,787	3,886	5,554	1,212	4,379	3,178
96	3,884	3,986	5,699	1,243	4,491	3,260
97	3,983	4,089	5,844	1,276	4,607	3,343
98	4,084	4,192	5,990	1,308	4,723	3,427
99+	4,187	4,294	6,141	1,341	4,840	3,512

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	7,908	n/a	n/a	n/a	n/a	n/a
65	1,873	1,921	2,747	598	2,165	1,486
66	1,873	1,921	2,747	598	2,165	1,486
67	1,873	1,921	2,747	598	2,165	1,486
68	1,891	1,943	2,775	605	2,187	1,539
69	1,935	1,988	2,837	620	2,240	1,603
70	1,984	2,038	2,915	635	2,295	1,662
71	2,046	2,100	3,001	655	2,364	1,720
72	2,108	2,166	3,094	677	2,442	1,779
73	2,178	2,236	3,197	697	2,519	1,841
74	2,257	2,314	3,308	722	2,607	1,903
75	2,333	2,396	3,424	747	2,699	1,964
76	2,417	2,481	3,544	772	2,793	2,027
77	2,501	2,565	3,670	801	2,892	2,092
78	2,586	2,652	3,794	827	2,988	2,163
79	2,665	2,739	3,913	854	3,083	2,232
80	2,750	2,822	4,036	880	3,180	2,310
81	2,836	2,910	4,165	910	3,282	2,382
82	2,923	2,998	4,286	935	3,379	2,452
83	3,011	3,090	4,418	966	3,483	2,528
84	3,099	3,180	4,546	992	3,587	2,602
85	3,211	3,296	4,712	1,029	3,714	2,696
86	3,303	3,388	4,846	1,058	3,821	2,773
87	3,398	3,488	4,985	1,088	3,929	2,851
88	3,491	3,584	5,125	1,119	4,039	2,932
89	3,589	3,683	5,268	1,151	4,149	3,013
90	3,688	3,786	5,412	1,180	4,265	3,097
91	3,788	3,889	5,559	1,213	4,380	3,181
92	3,889	3,993	5,710	1,246	4,498	3,267
93	3,993	4,100	5,859	1,280	4,620	3,353
94	4,101	4,208	6,018	1,315	4,742	3,441
95	4,208	4,318	6,173	1,346	4,866	3,531
96	4,315	4,429	6,332	1,382	4,992	3,622
97	4,424	4,542	6,492	1,417	5,121	3,714
98	4,539	4,657	6,656	1,454	5,246	3,808
99+	4,650	4,774	6,823	1,491	5,379	3,903

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 periods, use preferred rates.

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

Aetna Health Insurance Company

Annual premiums

For Use in ZIP Codes: 750-752, 760-761, 774, 776-777, 782, 784, 793-794

Male rates

Rates effective 2/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	8,186	n/a	n/a	n/a	n/a	n/a
65	1,938	1,989	2,842	620	2,241	1,539
66	1,938	1,989	2,842	620	2,241	1,539
67	1,938	1,989	2,842	620	2,241	1,539
68	1,957	2,010	2,872	627	2,265	1,591
69	2,001	2,054	2,938	641	2,316	1,657
70	2,055	2,109	3,016	658	2,376	1,720
71	2,118	2,173	3,106	679	2,446	1,782
72	2,185	2,240	3,207	699	2,525	1,843
73	2,253	2,314	3,309	722	2,607	1,904
74	2,334	2,396	3,424	748	2,699	1,970
75	2,417	2,481	3,545	772	2,793	2,034
76	2,501	2,566	3,669	800	2,891	2,098
77	2,587	2,653	3,797	828	2,995	2,168
78	2,676	2,747	3,927	857	3,094	2,241
79	2,760	2,834	4,050	883	3,190	2,312
80	2,845	2,921	4,176	912	3,291	2,389
81	2,937	3,014	4,309	941	3,397	2,464
82	3,024	3,103	4,435	968	3,498	2,538
83	3,116	3,199	4,572	999	3,603	2,616
84	3,207	3,293	4,707	1,027	3,710	2,693
85	3,324	3,411	4,876	1,064	3,845	2,790
86	3,421	3,511	5,017	1,095	3,955	2,870
87	3,517	3,607	5,161	1,125	4,068	2,951
88	3,615	3,708	5,303	1,157	4,178	3,035
89	3,715	3,813	5,451	1,190	4,296	3,120
90	3,818	3,917	5,600	1,223	4,415	3,203
91	3,920	4,025	5,753	1,256	4,535	3,291
92	4,027	4,133	5,906	1,289	4,654	3,381
93	4,135	4,245	6,064	1,324	4,781	3,471
94	4,245	4,355	6,225	1,360	4,909	3,561
95	4,353	4,468	6,387	1,395	5,037	3,654
96	4,468	4,584	6,554	1,431	5,167	3,749
97	4,582	4,701	6,720	1,466	5,298	3,843
98	4,697	4,819	6,888	1,505	5,431	3,942
99+	4,815	4,940	7,064	1,541	5,568	4,040

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	9,096	n/a	n/a	n/a	n/a	n/a
65	2,154	2,209	3,156	689	2,490	1,709
66	2,154	2,209	3,156	689	2,490	1,709
67	2,154	2,209	3,156	689	2,490	1,709
68	2,175	2,235	3,191	696	2,518	1,768
69	2,225	2,286	3,264	713	2,575	1,843
70	2,284	2,343	3,351	732	2,640	1,913
71	2,352	2,413	3,452	752	2,718	1,980
72	2,424	2,489	3,562	777	2,807	2,046
73	2,504	2,571	3,675	803	2,894	2,115
74	2,593	2,663	3,804	831	3,000	2,189
75	2,684	2,756	3,939	859	3,103	2,258
76	2,779	2,851	4,073	888	3,213	2,331
77	2,877	2,948	4,220	921	3,325	2,407
78	2,976	3,051	4,362	950	3,438	2,489
79	3,066	3,147	4,500	981	3,544	2,569
80	3,161	3,243	4,643	1,011	3,658	2,655
81	3,263	3,348	4,787	1,046	3,775	2,740
82	3,359	3,446	4,927	1,075	3,885	2,820
83	3,462	3,554	5,082	1,110	4,005	2,907
84	3,564	3,659	5,229	1,142	4,124	2,992
85	3,694	3,790	5,421	1,181	4,270	3,101
86	3,802	3,898	5,574	1,218	4,395	3,190
87	3,907	4,010	5,733	1,251	4,520	3,279
88	4,017	4,121	5,893	1,287	4,644	3,372
89	4,126	4,236	6,056	1,323	4,773	3,465
90	4,244	4,354	6,223	1,357	4,903	3,560
91	4,356	4,474	6,394	1,396	5,038	3,659
92	4,475	4,591	6,566	1,433	5,171	3,757
93	4,594	4,715	6,739	1,472	5,312	3,854
94	4,715	4,839	6,917	1,511	5,454	3,957
95	4,837	4,963	7,097	1,549	5,597	4,061
96	4,963	5,094	7,281	1,590	5,740	4,167
97	5,089	5,223	7,469	1,629	5,888	4,271
98	5,217	5,357	7,655	1,672	6,036	4,380
99+	5,349	5,489	7,846	1,714	6,184	4,488

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 periods, use preferred rates.

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

Aetna Health Insurance Company
Annual premiums
For use in: Rest of State
Female rates

Rates effective 2/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	6,471	---	---	---	---	---
65	1,532	1,572	2,247	490	1,771	1,216
66	1,532	1,572	2,247	490	1,771	1,216
67	1,532	1,572	2,247	490	1,771	1,216
68	1,548	1,588	2,271	495	1,789	1,259
69	1,584	1,625	2,323	508	1,832	1,310
70	1,624	1,668	2,385	520	1,879	1,361
71	1,672	1,717	2,458	536	1,934	1,409
72	1,727	1,770	2,533	552	1,996	1,457
73	1,781	1,830	2,616	571	2,062	1,505
74	1,846	1,893	2,707	591	2,134	1,557
75	1,910	1,961	2,803	612	2,209	1,607
76	1,977	2,028	2,900	632	2,285	1,658
77	2,046	2,099	3,002	654	2,366	1,713
78	2,116	2,170	3,104	677	2,446	1,771
79	2,181	2,240	3,200	698	2,522	1,827
80	2,250	2,309	3,303	721	2,604	1,888
81	2,320	2,381	3,405	744	2,684	1,948
82	2,388	2,454	3,506	764	2,765	2,006
83	2,465	2,530	3,616	789	2,849	2,068
84	2,537	2,602	3,721	811	2,933	2,129
85	2,627	2,697	3,855	841	3,039	2,206
86	2,705	2,774	3,964	865	3,126	2,269
87	2,780	2,854	4,078	890	3,215	2,332
88	2,857	2,932	4,193	915	3,304	2,398
89	2,936	3,013	4,308	941	3,395	2,466
90	3,020	3,098	4,429	966	3,490	2,532
91	3,100	3,181	4,549	993	3,585	2,602
92	3,183	3,268	4,669	1,019	3,681	2,671
93	3,267	3,354	4,794	1,047	3,778	2,744
94	3,354	3,443	4,923	1,074	3,881	2,816
95	3,443	3,533	5,049	1,102	3,981	2,889
96	3,531	3,624	5,181	1,130	4,083	2,964
97	3,621	3,717	5,313	1,160	4,188	3,039
98	3,713	3,811	5,445	1,189	4,294	3,115
99+	3,806	3,904	5,583	1,219	4,400	3,193

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	7,189	---	---	---	---	---
65	1,703	1,746	2,497	544	1,968	1,351
66	1,703	1,746	2,497	544	1,968	1,351
67	1,703	1,746	2,497	544	1,968	1,351
68	1,719	1,766	2,523	550	1,988	1,399
69	1,759	1,807	2,579	564	2,036	1,457
70	1,804	1,853	2,650	577	2,086	1,511
71	1,860	1,909	2,728	595	2,149	1,564
72	1,916	1,969	2,813	615	2,220	1,617
73	1,980	2,033	2,906	634	2,290	1,674
74	2,052	2,104	3,007	656	2,370	1,730
75	2,121	2,178	3,113	679	2,454	1,785
76	2,197	2,255	3,222	702	2,539	1,843
77	2,274	2,332	3,336	728	2,629	1,902
78	2,351	2,411	3,449	752	2,716	1,966
79	2,423	2,490	3,557	776	2,803	2,029
80	2,500	2,565	3,669	800	2,891	2,100
81	2,578	2,645	3,786	827	2,984	2,165
82	2,657	2,725	3,896	850	3,072	2,229
83	2,737	2,809	4,016	878	3,166	2,298
84	2,817	2,891	4,133	902	3,261	2,365
85	2,919	2,996	4,284	935	3,376	2,451
86	3,003	3,080	4,405	962	3,474	2,521
87	3,089	3,171	4,532	989	3,572	2,592
88	3,174	3,258	4,659	1,017	3,672	2,665
89	3,263	3,348	4,789	1,046	3,772	2,739
90	3,353	3,442	4,920	1,073	3,877	2,815
91	3,444	3,535	5,054	1,103	3,982	2,892
92	3,535	3,630	5,191	1,133	4,089	2,970
93	3,630	3,727	5,326	1,164	4,200	3,048
94	3,728	3,825	5,471	1,195	4,311	3,128
95	3,825	3,925	5,612	1,224	4,424	3,210
96	3,923	4,026	5,756	1,256	4,538	3,293
97	4,022	4,129	5,902	1,288	4,655	3,376
98	4,126	4,234	6,051	1,322	4,769	3,462
99+	4,227	4,340	6,203	1,355	4,890	3,548

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 periods, use preferred rates.

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

Aetna Health Insurance Company
Annual premiums
For use in: Rest of State
Male rates

Rates effective 2/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	7,442	---	---	---	---	---
65	1,762	1,808	2,584	564	2,037	1,399
66	1,762	1,808	2,584	564	2,037	1,399
67	1,762	1,808	2,584	564	2,037	1,399
68	1,779	1,827	2,611	570	2,059	1,446
69	1,819	1,867	2,671	583	2,105	1,506
70	1,868	1,917	2,742	598	2,160	1,564
71	1,925	1,975	2,824	617	2,224	1,620
72	1,986	2,036	2,915	635	2,295	1,675
73	2,048	2,104	3,008	656	2,370	1,731
74	2,122	2,178	3,113	680	2,454	1,791
75	2,197	2,255	3,223	702	2,539	1,849
76	2,274	2,333	3,335	727	2,628	1,907
77	2,352	2,412	3,452	753	2,723	1,971
78	2,433	2,497	3,570	779	2,813	2,037
79	2,509	2,576	3,682	803	2,900	2,102
80	2,586	2,655	3,796	829	2,992	2,172
81	2,670	2,740	3,917	855	3,088	2,240
82	2,749	2,821	4,032	880	3,180	2,307
83	2,833	2,908	4,156	908	3,275	2,378
84	2,915	2,994	4,279	934	3,373	2,448
85	3,022	3,101	4,433	967	3,495	2,536
86	3,110	3,192	4,561	995	3,595	2,609
87	3,197	3,279	4,692	1,023	3,698	2,683
88	3,286	3,371	4,821	1,052	3,798	2,759
89	3,377	3,466	4,955	1,082	3,905	2,836
90	3,471	3,561	5,091	1,112	4,014	2,912
91	3,564	3,659	5,230	1,142	4,123	2,992
92	3,661	3,757	5,369	1,172	4,231	3,074
93	3,759	3,859	5,513	1,204	4,346	3,155
94	3,859	3,959	5,659	1,236	4,463	3,237
95	3,957	4,062	5,806	1,268	4,579	3,322
96	4,062	4,167	5,958	1,301	4,697	3,408
97	4,165	4,274	6,109	1,333	4,816	3,494
98	4,270	4,381	6,262	1,368	4,937	3,584
99+	4,377	4,491	6,422	1,401	5,062	3,673

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	8,269	---	---	---	---	---
65	1,958	2,008	2,869	626	2,264	1,554
66	1,958	2,008	2,869	626	2,264	1,554
67	1,958	2,008	2,869	626	2,264	1,554
68	1,977	2,032	2,901	633	2,289	1,607
69	2,023	2,078	2,967	648	2,341	1,675
70	2,076	2,130	3,046	665	2,400	1,739
71	2,138	2,194	3,138	684	2,471	1,800
72	2,204	2,263	3,238	706	2,552	1,860
73	2,276	2,337	3,341	730	2,631	1,923
74	2,357	2,421	3,458	755	2,727	1,990
75	2,440	2,505	3,581	781	2,821	2,053
76	2,526	2,592	3,703	807	2,921	2,119
77	2,615	2,680	3,836	837	3,023	2,188
78	2,705	2,774	3,965	864	3,125	2,263
79	2,787	2,861	4,091	892	3,222	2,335
80	2,874	2,948	4,221	919	3,325	2,414
81	2,966	3,044	4,352	951	3,432	2,491
82	3,054	3,133	4,479	977	3,532	2,564
83	3,147	3,231	4,620	1,009	3,641	2,643
84	3,240	3,326	4,754	1,038	3,749	2,720
85	3,358	3,445	4,928	1,074	3,882	2,819
86	3,456	3,544	5,067	1,107	3,995	2,900
87	3,552	3,645	5,212	1,137	4,109	2,981
88	3,652	3,746	5,357	1,170	4,222	3,065
89	3,751	3,851	5,505	1,203	4,339	3,150
90	3,858	3,958	5,657	1,234	4,457	3,236
91	3,960	4,067	5,813	1,269	4,580	3,326
92	4,068	4,174	5,969	1,303	4,701	3,415
93	4,176	4,286	6,126	1,338	4,829	3,504
94	4,286	4,399	6,288	1,374	4,958	3,597
95	4,397	4,512	6,452	1,408	5,088	3,692
96	4,512	4,631	6,619	1,445	5,218	3,788
97	4,626	4,748	6,790	1,481	5,353	3,883
98	4,743	4,870	6,959	1,520	5,487	3,982
99+	4,863	4,990	7,133	1,558	5,622	4,080

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 periods, use preferred rates.

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

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. Any premium increase will become effective on the next policy anniversary date and only after filing and approval by the Texas Department of Insurance.

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

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

HOUSEHOLD DISCOUNT

In order to be eligible for the Household discount under an Aetna Health Insurance Company Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently be covered by an Aetna Health Insurance Company Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; or (b) be someone you resided with the past 12 months. The household discount will only be applicable if a policy for each applicant is issued. The discounted rate will be 7 percent lower than the individual rates and will apply as long as both policies remain in force.

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, Kentucky 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 expenses. 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.

LIMITATIONS AND EXCLUSIONS

This policy does not cover any loss incurred while your policy is not in force, except as provided in the Extension of Benefits section of your policy.

This policy will not pay for Hospital or Skilled Nursing Facility confinement incurred during a Part A Benefit Period while this policy is not in force, subject to the Extension of Benefits section of your policy.

This policy will not pay for any loss incurred which is paid for by Medicare.

This policy will not pay for any services for non-Medicare eligible expenses, including, but not limited to, routine exams, take-home drugs and eye refractions.

This policy will not pay for services for which a charge is not normally made in the absence of insurance.

This policy will not pay for a loss that is payable under any other Medicare supplement insurance policy or certificate.

This policy will not pay for a loss that is payable under any other insurance which paid benefits for the same loss on an expense incurred basis.

REFUND OF PREMIUM

The company shall refund any premium paid for the period beyond the end of the policy month in which the death or cancellation occurred. Unearned premium shall be paid in a lump sum to your estate no later than thirty (30) days after receipt of proof of death or cancellation is received by the company.

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.

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 $1,632	$0	$1,632 (Part A Deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN A

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN B

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 F

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$240 (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 $2,800 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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.

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $240 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 $2,800 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$240 (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 $2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,800 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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 G

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 N

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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