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

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Rates effective: 02/2025 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 2025[2]					**$7,220[2]**	**$3,610[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,870** 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 2/1/2025

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	2,258	2,317	3,552	657	2,801	1,923
66	2,258	2,317	3,552	657	2,801	1,923
67	2,258	2,317	3,552	657	2,801	1,923
68	2,282	2,341	3,591	663	2,829	1,991
69	2,334	2,396	3,673	681	2,897	2,072
70	2,393	2,459	3,771	697	2,971	2,152
71	2,464	2,531	3,886	718	3,058	2,228
72	2,546	2,609	4,005	740	3,156	2,303
73	2,625	2,697	4,137	765	3,260	2,380
74	2,722	2,790	4,280	792	3,374	2,462
75	2,815	2,890	4,433	820	3,493	2,541
76	2,915	2,990	4,585	847	3,613	2,621
77	3,016	3,094	4,746	876	3,741	2,708
78	3,120	3,199	4,908	907	3,867	2,801
79	3,215	3,302	5,060	935	3,988	2,889
80	3,317	3,404	5,223	966	4,118	2,986
81	3,420	3,509	5,384	997	4,244	3,081
82	3,520	3,617	5,544	1,024	4,372	3,172
83	3,634	3,729	5,718	1,057	4,505	3,270
84	3,740	3,835	5,884	1,087	4,638	3,366
85	3,873	3,976	6,096	1,127	4,805	3,488
86	3,988	4,088	6,269	1,159	4,943	3,587
87	4,098	4,206	6,448	1,193	5,084	3,688
88	4,212	4,322	6,630	1,226	5,225	3,792
89	4,328	4,441	6,811	1,261	5,368	3,899
90	4,451	4,567	7,003	1,294	5,518	4,004
91	4,569	4,689	7,193	1,331	5,668	4,114
92	4,691	4,817	7,382	1,365	5,821	4,224
93	4,816	4,943	7,580	1,403	5,974	4,339
94	4,943	5,075	7,784	1,439	6,137	4,453
95	5,075	5,207	7,984	1,477	6,295	4,568
96	5,205	5,341	8,193	1,514	6,456	4,687
97	5,337	5,479	8,400	1,554	6,622	4,805
98	5,473	5,617	8,610	1,593	6,790	4,926
99+	5,611	5,754	8,828	1,633	6,957	5,049

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	11,078	n/a	n/a	n/a	n/a	n/a
65	2,510	2,574	3,948	729	3,111	2,136
66	2,510	2,574	3,948	729	3,111	2,136
67	2,510	2,574	3,948	729	3,111	2,136
68	2,534	2,604	3,989	737	3,144	2,212
69	2,593	2,664	4,078	756	3,219	2,303
70	2,659	2,731	4,190	773	3,298	2,389
71	2,742	2,814	4,313	797	3,398	2,474
72	2,825	2,902	4,447	824	3,511	2,557
73	2,919	2,996	4,595	850	3,621	2,647
74	3,024	3,101	4,754	879	3,748	2,735
75	3,126	3,211	4,922	910	3,881	2,822
76	3,239	3,325	5,095	941	4,015	2,915
77	3,351	3,437	5,274	976	4,157	3,007
78	3,465	3,554	5,454	1,008	4,295	3,109
79	3,571	3,670	5,624	1,040	4,433	3,208
80	3,685	3,781	5,801	1,072	4,571	3,321
81	3,800	3,899	5,986	1,108	4,718	3,424
82	3,917	4,017	6,160	1,139	4,858	3,524
83	4,035	4,141	6,350	1,177	5,006	3,634
84	4,153	4,261	6,535	1,209	5,156	3,740
85	4,303	4,417	6,774	1,253	5,339	3,875
86	4,426	4,540	6,965	1,289	5,493	3,987
87	4,553	4,674	7,166	1,325	5,648	4,099
88	4,678	4,803	7,367	1,363	5,806	4,214
89	4,809	4,935	7,572	1,402	5,964	4,331
90	4,942	5,073	7,780	1,438	6,131	4,451
91	5,076	5,211	7,992	1,478	6,297	4,573
92	5,211	5,351	8,208	1,518	6,466	4,697
93	5,351	5,494	8,422	1,560	6,641	4,820
94	5,495	5,639	8,651	1,601	6,817	4,946
95	5,639	5,786	8,873	1,640	6,995	5,076
96	5,782	5,935	9,101	1,683	7,176	5,207
97	5,928	6,086	9,332	1,726	7,361	5,339
98	6,082	6,240	9,568	1,771	7,540	5,474
99+	6,231	6,397	9,809	1,816	7,732	5,611

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						ATTAINED AGE	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
Under 65	11,468	n/a	n/a	n/a	n/a	n/a	Under 65	12,742	n/a	n/a	n/a	n/a	n/a
65	2,597	2,665	4,086	756	3,221	2,212	65	2,886	2,960	4,536	839	3,580	2,458
66	2,597	2,665	4,086	756	3,221	2,212	66	2,886	2,960	4,536	839	3,580	2,458
67	2,597	2,665	4,086	756	3,221	2,212	67	2,886	2,960	4,536	839	3,580	2,458
68	2,622	2,693	4,129	764	3,256	2,286	68	2,915	2,995	4,587	848	3,619	2,541
69	2,681	2,752	4,224	781	3,329	2,381	69	2,982	3,063	4,691	868	3,701	2,649
70	2,754	2,826	4,336	801	3,416	2,474	70	3,061	3,140	4,816	891	3,795	2,750
71	2,838	2,912	4,465	827	3,516	2,562	71	3,152	3,233	4,962	917	3,907	2,846
72	2,928	3,002	4,610	851	3,629	2,649	72	3,248	3,335	5,120	946	4,035	2,941
73	3,019	3,101	4,756	879	3,748	2,738	73	3,355	3,445	5,282	978	4,161	3,040
74	3,128	3,211	4,922	911	3,881	2,831	74	3,475	3,568	5,467	1,012	4,312	3,146
75	3,239	3,325	5,096	941	4,015	2,924	75	3,597	3,693	5,663	1,047	4,461	3,247
76	3,351	3,438	5,273	974	4,155	3,015	76	3,724	3,820	5,856	1,081	4,619	3,350
77	3,467	3,555	5,458	1,009	4,305	3,117	77	3,855	3,950	6,065	1,122	4,780	3,460
78	3,586	3,681	5,645	1,044	4,447	3,221	78	3,988	4,088	6,270	1,158	4,942	3,578
79	3,698	3,798	5,822	1,076	4,585	3,323	79	4,108	4,217	6,468	1,195	5,095	3,692
80	3,812	3,914	6,002	1,111	4,732	3,434	80	4,236	4,346	6,675	1,231	5,258	3,818
81	3,936	4,039	6,193	1,146	4,883	3,542	81	4,372	4,486	6,881	1,274	5,427	3,938
82	4,052	4,158	6,376	1,179	5,028	3,647	82	4,501	4,618	7,082	1,309	5,585	4,055
83	4,175	4,287	6,571	1,217	5,179	3,760	83	4,639	4,762	7,306	1,352	5,757	4,179
84	4,297	4,413	6,766	1,252	5,333	3,871	84	4,776	4,903	7,517	1,391	5,928	4,301
85	4,454	4,571	7,010	1,296	5,526	4,009	85	4,950	5,079	7,792	1,439	6,139	4,457
86	4,584	4,705	7,212	1,333	5,684	4,126	86	5,095	5,223	8,012	1,483	6,317	4,585
87	4,713	4,833	7,420	1,371	5,848	4,242	87	5,235	5,373	8,241	1,524	6,498	4,714
88	4,844	4,969	7,623	1,410	6,006	4,363	88	5,383	5,522	8,470	1,568	6,676	4,847
89	4,978	5,109	7,835	1,450	6,175	4,484	89	5,529	5,676	8,705	1,612	6,861	4,981
90	5,116	5,249	8,049	1,490	6,348	4,604	90	5,687	5,834	8,945	1,654	7,047	5,116
91	5,253	5,394	8,269	1,530	6,519	4,732	91	5,837	5,995	9,191	1,700	7,241	5,260
92	5,396	5,538	8,489	1,570	6,691	4,860	92	5,997	6,152	9,438	1,746	7,433	5,400
93	5,541	5,688	8,717	1,613	6,872	4,989	93	6,156	6,318	9,687	1,793	7,635	5,541
94	5,688	5,836	8,949	1,656	7,056	5,119	94	6,318	6,484	9,943	1,841	7,839	5,687
95	5,833	5,987	9,180	1,699	7,240	5,253	95	6,482	6,650	10,201	1,887	8,045	5,838
96	5,987	6,143	9,420	1,743	7,426	5,388	96	6,650	6,826	10,465	1,936	8,250	5,990
97	6,140	6,299	9,660	1,786	7,615	5,525	97	6,819	6,999	10,736	1,985	8,465	6,140
98	6,294	6,457	9,901	1,833	7,807	5,667	98	6,991	7,178	11,004	2,037	8,677	6,297
99+	6,452	6,620	10,155	1,877	8,004	5,808	99+	7,168	7,355	11,279	2,088	8,890	6,451

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	8,186	n/a	n/a	n/a	n/a	n/a
65	1,854	1,902	2,916	539	2,299	1,579
66	1,854	1,902	2,916	539	2,299	1,579
67	1,854	1,902	2,916	539	2,299	1,579
68	1,873	1,922	2,948	545	2,322	1,635
69	1,916	1,967	3,015	559	2,378	1,701
70	1,965	2,019	3,095	572	2,439	1,767
71	2,023	2,078	3,190	590	2,510	1,829
72	2,090	2,142	3,288	607	2,591	1,891
73	2,155	2,214	3,396	628	2,676	1,954
74	2,234	2,290	3,513	650	2,770	2,021
75	2,311	2,373	3,639	673	2,868	2,086
76	2,393	2,454	3,764	695	2,966	2,152
77	2,476	2,540	3,896	719	3,071	2,223
78	2,561	2,626	4,029	745	3,175	2,299
79	2,639	2,710	4,154	768	3,274	2,372
80	2,723	2,794	4,288	793	3,380	2,451
81	2,807	2,881	4,420	818	3,484	2,529
82	2,890	2,969	4,551	840	3,589	2,604
83	2,983	3,061	4,694	868	3,698	2,684
84	3,070	3,148	4,830	892	3,807	2,763
85	3,179	3,264	5,004	925	3,945	2,863
86	3,274	3,356	5,146	952	4,058	2,945
87	3,364	3,453	5,293	979	4,173	3,027
88	3,457	3,548	5,443	1,007	4,289	3,113
89	3,553	3,645	5,591	1,035	4,407	3,201
90	3,654	3,749	5,749	1,063	4,530	3,287
91	3,751	3,849	5,905	1,092	4,653	3,377
92	3,851	3,955	6,060	1,121	4,778	3,467
93	3,953	4,058	6,223	1,152	4,904	3,562
94	4,058	4,166	6,390	1,181	5,038	3,655
95	4,166	4,275	6,554	1,212	5,168	3,750
96	4,272	4,385	6,725	1,243	5,300	3,848
97	4,381	4,498	6,896	1,276	5,436	3,945
98	4,492	4,611	7,068	1,308	5,574	4,044
99+	4,606	4,723	7,247	1,341	5,711	4,145

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	9,094	n/a	n/a	n/a	n/a	n/a
65	2,060	2,113	3,241	598	2,554	1,753
66	2,060	2,113	3,241	598	2,554	1,753
67	2,060	2,113	3,241	598	2,554	1,753
68	2,080	2,137	3,275	605	2,581	1,816
69	2,129	2,187	3,347	620	2,642	1,891
70	2,182	2,242	3,440	635	2,707	1,961
71	2,251	2,310	3,541	655	2,790	2,031
72	2,319	2,383	3,651	677	2,882	2,099
73	2,396	2,460	3,772	697	2,972	2,173
74	2,483	2,545	3,903	722	3,077	2,245
75	2,566	2,636	4,040	747	3,186	2,317
76	2,659	2,729	4,182	772	3,296	2,393
77	2,751	2,822	4,330	801	3,412	2,468
78	2,845	2,917	4,477	827	3,526	2,552
79	2,932	3,013	4,617	854	3,639	2,633
80	3,025	3,104	4,762	880	3,752	2,726
81	3,120	3,201	4,914	910	3,873	2,811
82	3,215	3,298	5,057	935	3,988	2,893
83	3,312	3,399	5,213	966	4,110	2,983
84	3,409	3,498	5,365	992	4,233	3,070
85	3,532	3,626	5,561	1,029	4,382	3,181
86	3,633	3,727	5,718	1,058	4,509	3,273
87	3,738	3,837	5,883	1,088	4,637	3,365
88	3,840	3,942	6,048	1,119	4,766	3,460
89	3,948	4,051	6,216	1,151	4,896	3,555
90	4,057	4,165	6,387	1,180	5,033	3,654
91	4,167	4,278	6,560	1,213	5,169	3,754
92	4,278	4,392	6,738	1,246	5,308	3,856
93	4,392	4,510	6,914	1,280	5,452	3,957
94	4,511	4,629	7,102	1,315	5,596	4,060
95	4,629	4,750	7,284	1,346	5,742	4,167
96	4,747	4,872	7,471	1,382	5,891	4,275
97	4,866	4,996	7,660	1,417	6,042	4,382
98	4,993	5,123	7,854	1,454	6,190	4,494
99+	5,115	5,251	8,052	1,491	6,347	4,606

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	9,414	n/a	n/a	n/a	n/a	n/a
65	2,132	2,188	3,354	620	2,644	1,816
66	2,132	2,188	3,354	620	2,644	1,816
67	2,132	2,188	3,354	620	2,644	1,816
68	2,153	2,211	3,389	627	2,673	1,877
69	2,201	2,259	3,467	641	2,732	1,955
70	2,261	2,320	3,560	658	2,804	2,031
71	2,330	2,390	3,665	679	2,886	2,103
72	2,404	2,464	3,784	699	2,979	2,175
73	2,478	2,545	3,904	722	3,077	2,247
74	2,567	2,636	4,040	748	3,186	2,324
75	2,659	2,729	4,183	772	3,296	2,400
76	2,751	2,823	4,329	800	3,411	2,475
77	2,846	2,918	4,480	828	3,534	2,559
78	2,944	3,022	4,634	857	3,651	2,644
79	3,036	3,117	4,780	883	3,764	2,728
80	3,130	3,213	4,927	912	3,884	2,819
81	3,231	3,315	5,084	941	4,008	2,907
82	3,326	3,413	5,234	968	4,127	2,994
83	3,428	3,519	5,394	999	4,252	3,087
84	3,528	3,622	5,554	1,027	4,378	3,178
85	3,656	3,752	5,754	1,064	4,536	3,291
86	3,763	3,862	5,920	1,095	4,666	3,387
87	3,869	3,968	6,091	1,125	4,800	3,483
88	3,977	4,079	6,258	1,157	4,930	3,582
89	4,087	4,194	6,432	1,190	5,069	3,681
90	4,200	4,309	6,608	1,223	5,211	3,780
91	4,312	4,428	6,788	1,256	5,352	3,884
92	4,430	4,546	6,969	1,289	5,492	3,990
93	4,549	4,670	7,156	1,324	5,641	4,095
94	4,670	4,791	7,346	1,360	5,793	4,202
95	4,788	4,915	7,536	1,395	5,943	4,312
96	4,915	5,042	7,733	1,431	6,096	4,423
97	5,040	5,171	7,930	1,466	6,251	4,535
98	5,167	5,301	8,128	1,505	6,409	4,652
99+	5,297	5,434	8,336	1,541	6,570	4,767

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	10,460	n/a	n/a	n/a	n/a	n/a
65	2,369	2,430	3,724	689	2,939	2,017
66	2,369	2,430	3,724	689	2,939	2,017
67	2,369	2,430	3,724	689	2,939	2,017
68	2,393	2,459	3,765	696	2,971	2,086
69	2,448	2,515	3,851	713	3,038	2,175
70	2,512	2,577	3,953	732	3,115	2,257
71	2,587	2,654	4,073	752	3,208	2,336
72	2,666	2,738	4,203	777	3,312	2,415
73	2,754	2,828	4,336	803	3,416	2,496
74	2,852	2,929	4,488	831	3,540	2,583
75	2,952	3,032	4,649	859	3,662	2,665
76	3,057	3,136	4,807	888	3,792	2,750
77	3,165	3,243	4,979	921	3,924	2,840
78	3,274	3,356	5,147	950	4,057	2,937
79	3,373	3,462	5,310	981	4,182	3,031
80	3,477	3,567	5,479	1,011	4,316	3,134
81	3,589	3,683	5,649	1,046	4,455	3,233
82	3,695	3,791	5,814	1,075	4,585	3,329
83	3,808	3,909	5,997	1,110	4,726	3,431
84	3,920	4,025	6,171	1,142	4,866	3,531
85	4,063	4,169	6,397	1,181	5,039	3,659
86	4,182	4,288	6,577	1,218	5,185	3,764
87	4,298	4,411	6,765	1,251	5,334	3,870
88	4,419	4,533	6,953	1,287	5,480	3,979
89	4,539	4,660	7,146	1,323	5,632	4,089
90	4,668	4,789	7,343	1,357	5,785	4,200
91	4,792	4,921	7,545	1,396	5,944	4,318
92	4,923	5,050	7,747	1,433	6,102	4,433
93	5,053	5,187	7,952	1,472	6,268	4,549
94	5,187	5,323	8,162	1,511	6,435	4,668
95	5,321	5,459	8,374	1,549	6,604	4,793
96	5,459	5,603	8,591	1,590	6,773	4,917
97	5,598	5,745	8,813	1,629	6,949	5,040
98	5,739	5,893	9,033	1,672	7,123	5,169
99+	5,884	6,038	9,259	1,714	7,297	5,295

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	7,442	---	---	---	---	---
65	1,685	1,729	2,651	490	2,090	1,435
66	1,685	1,729	2,651	490	2,090	1,435
67	1,685	1,729	2,651	490	2,090	1,435
68	1,703	1,747	2,680	495	2,111	1,486
69	1,742	1,788	2,741	508	2,162	1,546
70	1,786	1,835	2,814	520	2,217	1,606
71	1,839	1,889	2,900	536	2,282	1,663
72	1,900	1,947	2,989	552	2,355	1,719
73	1,959	2,013	3,087	571	2,433	1,776
74	2,031	2,082	3,194	591	2,518	1,837
75	2,101	2,157	3,308	612	2,607	1,896
76	2,175	2,231	3,422	632	2,696	1,956
77	2,251	2,309	3,542	654	2,792	2,021
78	2,328	2,387	3,663	677	2,886	2,090
79	2,399	2,464	3,776	698	2,976	2,156
80	2,475	2,540	3,898	721	3,073	2,228
81	2,552	2,619	4,018	744	3,167	2,299
82	2,627	2,699	4,137	764	3,263	2,367
83	2,712	2,783	4,267	789	3,362	2,440
84	2,791	2,862	4,391	811	3,461	2,512
85	2,890	2,967	4,549	841	3,586	2,603
86	2,976	3,051	4,678	865	3,689	2,677
87	3,058	3,139	4,812	890	3,794	2,752
88	3,143	3,225	4,948	915	3,899	2,830
89	3,230	3,314	5,083	941	4,006	2,910
90	3,322	3,408	5,226	966	4,118	2,988
91	3,410	3,499	5,368	993	4,230	3,070
92	3,501	3,595	5,509	1,019	4,344	3,152
93	3,594	3,689	5,657	1,047	4,458	3,238
94	3,689	3,787	5,809	1,074	4,580	3,323
95	3,787	3,886	5,958	1,102	4,698	3,409
96	3,884	3,986	6,114	1,130	4,818	3,498
97	3,983	4,089	6,269	1,160	4,942	3,586
98	4,084	4,192	6,425	1,189	5,067	3,676
99+	4,187	4,294	6,588	1,219	5,192	3,768

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	8,267	---	---	---	---	---
65	1,873	1,921	2,946	544	2,322	1,594
66	1,873	1,921	2,946	544	2,322	1,594
67	1,873	1,921	2,946	544	2,322	1,594
68	1,891	1,943	2,977	550	2,346	1,651
69	1,935	1,988	3,043	564	2,402	1,719
70	1,984	2,038	3,127	577	2,461	1,783
71	2,046	2,100	3,219	595	2,536	1,846
72	2,108	2,166	3,319	615	2,620	1,908
73	2,178	2,236	3,429	634	2,702	1,975
74	2,257	2,314	3,548	656	2,797	2,041
75	2,333	2,396	3,673	679	2,896	2,106
76	2,417	2,481	3,802	702	2,996	2,175
77	2,501	2,565	3,936	728	3,102	2,244
78	2,586	2,652	4,070	752	3,205	2,320
79	2,665	2,739	4,197	776	3,308	2,394
80	2,750	2,822	4,329	800	3,411	2,478
81	2,836	2,910	4,467	827	3,521	2,555
82	2,923	2,998	4,597	850	3,625	2,630
83	3,011	3,090	4,739	878	3,736	2,712
84	3,099	3,180	4,877	902	3,848	2,791
85	3,211	3,296	5,055	935	3,984	2,892
86	3,303	3,388	5,198	962	4,099	2,975
87	3,398	3,488	5,348	989	4,215	3,059
88	3,491	3,584	5,498	1,017	4,333	3,145
89	3,589	3,683	5,651	1,046	4,451	3,232
90	3,688	3,786	5,806	1,073	4,575	3,322
91	3,788	3,889	5,964	1,103	4,699	3,413
92	3,889	3,993	6,125	1,133	4,825	3,505
93	3,993	4,100	6,285	1,164	4,956	3,597
94	4,101	4,208	6,456	1,195	5,087	3,691
95	4,208	4,318	6,622	1,224	5,220	3,788
96	4,315	4,429	6,792	1,256	5,355	3,886
97	4,424	4,542	6,964	1,288	5,493	3,984
98	4,539	4,657	7,140	1,322	5,627	4,085
99+	4,650	4,774	7,320	1,355	5,770	4,187

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						ATTAINED AGE	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
Under 65	8,558	---	---	---	---	---	Under 65	9,509	---	---	---	---	---
65	1,938	1,989	3,049	564	2,404	1,651	65	2,154	2,209	3,385	626	2,672	1,834
66	1,938	1,989	3,049	564	2,404	1,651	66	2,154	2,209	3,385	626	2,672	1,834
67	1,938	1,989	3,049	564	2,404	1,651	67	2,154	2,209	3,385	626	2,672	1,834
68	1,957	2,010	3,081	570	2,430	1,706	68	2,175	2,235	3,423	633	2,701	1,896
69	2,001	2,054	3,152	583	2,484	1,777	69	2,225	2,286	3,501	648	2,762	1,977
70	2,055	2,109	3,236	598	2,549	1,846	70	2,284	2,343	3,594	665	2,832	2,052
71	2,118	2,173	3,332	617	2,624	1,912	71	2,352	2,413	3,703	684	2,916	2,124
72	2,185	2,240	3,440	635	2,708	1,977	72	2,424	2,489	3,821	706	3,011	2,195
73	2,253	2,314	3,549	656	2,797	2,043	73	2,504	2,571	3,942	730	3,105	2,269
74	2,334	2,396	3,673	680	2,896	2,113	74	2,593	2,663	4,080	755	3,218	2,348
75	2,417	2,481	3,803	702	2,996	2,182	75	2,684	2,756	4,226	781	3,329	2,423
76	2,501	2,566	3,935	727	3,101	2,250	76	2,779	2,851	4,370	807	3,447	2,500
77	2,587	2,653	4,073	753	3,213	2,326	77	2,877	2,948	4,526	837	3,567	2,582
78	2,676	2,747	4,213	779	3,319	2,404	78	2,976	3,051	4,679	864	3,688	2,670
79	2,760	2,834	4,345	803	3,422	2,480	79	3,066	3,147	4,827	892	3,802	2,755
80	2,845	2,921	4,479	829	3,531	2,563	80	3,161	3,243	4,981	919	3,924	2,849
81	2,937	3,014	4,622	855	3,644	2,643	81	3,263	3,348	5,135	951	4,050	2,939
82	3,024	3,103	4,758	880	3,752	2,722	82	3,359	3,446	5,285	977	4,168	3,026
83	3,116	3,199	4,904	908	3,865	2,806	83	3,462	3,554	5,452	1,009	4,296	3,119
84	3,207	3,293	5,049	934	3,980	2,889	84	3,564	3,659	5,610	1,038	4,424	3,210
85	3,324	3,411	5,231	967	4,124	2,992	85	3,694	3,790	5,815	1,074	4,581	3,326
86	3,421	3,511	5,382	995	4,242	3,079	86	3,802	3,898	5,979	1,107	4,714	3,422
87	3,517	3,607	5,537	1,023	4,364	3,166	87	3,907	4,010	6,150	1,137	4,849	3,518
88	3,615	3,708	5,689	1,052	4,482	3,256	88	4,017	4,121	6,321	1,170	4,982	3,617
89	3,715	3,813	5,847	1,082	4,608	3,346	89	4,126	4,236	6,496	1,203	5,120	3,717
90	3,818	3,917	6,007	1,112	4,737	3,436	90	4,244	4,354	6,675	1,234	5,259	3,818
91	3,920	4,025	6,171	1,142	4,865	3,531	91	4,356	4,474	6,859	1,269	5,404	3,925
92	4,027	4,133	6,335	1,172	4,993	3,627	92	4,475	4,591	7,043	1,303	5,547	4,030
93	4,135	4,245	6,505	1,204	5,128	3,723	93	4,594	4,715	7,229	1,338	5,698	4,135
94	4,245	4,355	6,678	1,236	5,266	3,820	94	4,715	4,839	7,420	1,374	5,850	4,244
95	4,353	4,468	6,851	1,268	5,403	3,920	95	4,837	4,963	7,613	1,408	6,004	4,357
96	4,468	4,584	7,030	1,301	5,542	4,021	96	4,963	5,094	7,810	1,445	6,157	4,470
97	4,582	4,701	7,209	1,333	5,683	4,123	97	5,089	5,223	8,012	1,481	6,317	4,582
98	4,697	4,819	7,389	1,368	5,826	4,229	98	5,217	5,357	8,212	1,520	6,475	4,699
99+	4,815	4,940	7,578	1,401	5,973	4,334	99+	5,349	5,489	8,417	1,558	6,634	4,814

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 $1,676	$0	$1,676 (Part A Deductible)
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	$0	Up to $209.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN A

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

*Once you have been billed $257 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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	$0	Up to $209.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN B

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

*Once you have been billed $257 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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 **$257** 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 **$257** of Medicare-Approved amounts*	$0	$257 (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 **$257** of Medicare-Approved amounts*	$0	$257 (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 **$257** of Medicare-Approved amounts*	$0	$257 (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 $2,870 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,870. 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 $2,870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,870 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 $257 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 $2,870 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,870. 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 $2,870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,870 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 $257 of Medicare-Approved amounts*	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$257 (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 $2,870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,870 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $257 of Medicare-Approved amounts*	$0	$257 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,870 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 $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 $257 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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 $257 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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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