Aetna Application Packet

Thank you for your interest in the Aetna Medicare Supplement plan!

Attached is a copy of the policy Outline of Coverage and we have supplied you with a link to a printable copy of the Enrollment.

Should you decide to apply by upload/mail/fax/email, the printable application needs to be reviewed and signed by an Agent before it can be submitted to Aetna. You may upload, email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: cs@cda-insurance.com
- Secure File Upload: Click here
- Mail: CDA Insurance LLC
  PO Box 26540
  Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf) Download Policy Outline (.pdf) Download Application (.pdf)

Our website: http://www.medicare-texas.net

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

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: 02/2020 B

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 2020[2]					$5,880[2]	$2,940[2]				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,340 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: 750-752, 760-761, 774, 776-777, 782, 784, 793-794

Female Rates

Rates Effective 2/1/2020

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,920	n/a	n/a	n/a	n/a	n/a
65	1,240	1,296	1,630	518	1,297	1,036
66	1,240	1,296	1,630	518	1,297	1,036
67	1,240	1,296	1,630	518	1,297	1,036
68	1,252	1,309	1,647	524	1,310	1,073
69	1,282	1,340	1,685	537	1,341	1,117
70	1,315	1,375	1,730	550	1,376	1,159
71	1,354	1,416	1,782	567	1,417	1,200
72	1,397	1,460	1,838	584	1,462	1,241
73	1,442	1,508	1,898	604	1,509	1,283
74	1,494	1,561	1,964	625	1,562	1,327
75	1,546	1,616	2,033	647	1,617	1,370
76	1,601	1,672	2,104	669	1,673	1,412
77	1,657	1,730	2,178	692	1,733	1,460
78	1,713	1,790	2,252	716	1,791	1,509
79	1,766	1,846	2,322	738	1,847	1,558
80	1,821	1,903	2,396	762	1,905	1,609
81	1,878	1,964	2,471	787	1,966	1,660
82	1,934	2,022	2,543	809	2,024	1,709
83	1,994	2,085	2,622	835	2,086	1,762
84	2,053	2,145	2,699	858	2,147	1,814
85	2,126	2,223	2,797	890	2,225	1,880
86	2,188	2,287	2,877	915	2,289	1,934
87	2,250	2,352	2,959	942	2,354	1,988
88	2,312	2,417	3,042	968	2,419	2,044
89	2,376	2,484	3,126	996	2,486	2,101
90	2,443	2,553	3,212	1,022	2,555	2,158
91	2,509	2,622	3,300	1,051	2,625	2,218
92	2,576	2,693	3,388	1,078	2,695	2,277
93	2,644	2,764	3,478	1,108	2,767	2,338
94	2,715	2,838	3,571	1,136	2,841	2,399
95	2,786	2,912	3,663	1,166	2,915	2,462
96	2,858	2,987	3,759	1,196	2,990	2,526
97	2,930	3,064	3,854	1,227	3,067	2,589
98	3,005	3,141	3,951	1,257	3,144	2,655
99+	3,080	3,219	4,050	1,289	3,222	2,721

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	5,466	n/a	n/a	n/a	n/a	n/a
65	1,378	1,440	1,811	575	1,441	1,152
66	1,378	1,440	1,811	575	1,441	1,152
67	1,378	1,440	1,811	575	1,441	1,152
68	1,392	1,455	1,830	582	1,456	1,191
69	1,423	1,489	1,872	596	1,491	1,241
70	1,461	1,527	1,922	611	1,528	1,288
71	1,505	1,573	1,979	629	1,574	1,333
72	1,552	1,623	2,042	650	1,625	1,378
73	1,603	1,675	2,109	671	1,676	1,426
74	1,660	1,735	2,181	694	1,736	1,474
75	1,717	1,795	2,258	718	1,796	1,521
76	1,778	1,858	2,338	743	1,859	1,570
77	1,840	1,922	2,420	770	1,925	1,621
78	1,903	1,988	2,503	795	1,989	1,676
79	1,962	2,052	2,581	821	2,053	1,730
80	2,023	2,114	2,661	846	2,118	1,789
81	2,087	2,181	2,746	875	2,185	1,845
82	2,149	2,246	2,826	899	2,248	1,900
83	2,214	2,316	2,914	928	2,318	1,958
84	2,280	2,383	2,999	954	2,387	2,015
85	2,363	2,470	3,108	989	2,472	2,089
86	2,431	2,540	3,197	1,018	2,543	2,148
87	2,500	2,614	3,288	1,046	2,616	2,209
88	2,570	2,685	3,379	1,076	2,688	2,270
89	2,640	2,760	3,474	1,107	2,762	2,334
90	2,714	2,837	3,570	1,135	2,839	2,398
91	2,787	2,914	3,666	1,167	2,916	2,464
92	2,862	2,992	3,765	1,198	2,994	2,530
93	2,938	3,072	3,864	1,231	3,075	2,597
94	3,017	3,153	3,968	1,264	3,156	2,665
95	3,095	3,235	4,071	1,295	3,240	2,736
96	3,176	3,319	4,176	1,329	3,322	2,806
97	3,256	3,403	4,282	1,362	3,408	2,878
98	3,340	3,489	4,390	1,398	3,493	2,950
99+	3,422	3,577	4,500	1,433	3,581	3,024

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

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

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

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

Aetna Health Insurance Company

Annual Premiums

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

Male Rates

Rates Effective 2/1/2020

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	5,658	n/a	n/a	n/a	n/a	n/a
65	1,426	1,491	1,874	596	1,492	1,191
66	1,426	1,491	1,874	596	1,492	1,191
67	1,426	1,491	1,874	596	1,492	1,191
68	1,440	1,506	1,894	603	1,507	1,233
69	1,473	1,540	1,938	617	1,541	1,284
70	1,513	1,581	1,989	633	1,582	1,333
71	1,558	1,628	2,049	652	1,629	1,381
72	1,607	1,679	2,114	672	1,681	1,427
73	1,659	1,735	2,182	694	1,736	1,475
74	1,718	1,795	2,258	719	1,796	1,526
75	1,778	1,858	2,339	743	1,859	1,575
76	1,840	1,923	2,419	769	1,924	1,625
77	1,904	1,989	2,505	796	1,993	1,679
78	1,969	2,058	2,589	824	2,059	1,736
79	2,031	2,123	2,672	849	2,124	1,791
80	2,093	2,188	2,754	877	2,191	1,850
81	2,160	2,258	2,841	904	2,261	1,909
82	2,225	2,324	2,925	931	2,329	1,966
83	2,294	2,398	3,016	960	2,399	2,026
84	2,360	2,467	3,104	988	2,470	2,086
85	2,445	2,556	3,216	1,023	2,559	2,162
86	2,517	2,630	3,309	1,053	2,632	2,224
87	2,587	2,704	3,403	1,082	2,707	2,286
88	2,659	2,780	3,498	1,113	2,782	2,351
89	2,734	2,857	3,595	1,144	2,859	2,417
90	2,809	2,935	3,694	1,176	2,938	2,482
91	2,884	3,016	3,795	1,208	3,018	2,550
92	2,962	3,097	3,896	1,240	3,099	2,619
93	3,042	3,180	4,000	1,274	3,182	2,688
94	3,123	3,263	4,105	1,307	3,267	2,759
95	3,203	3,348	4,213	1,341	3,353	2,831
96	3,287	3,434	4,323	1,376	3,439	2,904
97	3,370	3,523	4,432	1,410	3,527	2,978
98	3,456	3,611	4,544	1,447	3,615	3,054
99+	3,542	3,702	4,659	1,482	3,706	3,130

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	6,287	n/a	n/a	n/a	n/a	n/a
65	1,584	1,656	2,082	662	1,658	1,324
66	1,584	1,656	2,082	662	1,658	1,324
67	1,584	1,656	2,082	662	1,658	1,324
68	1,601	1,674	2,105	670	1,675	1,370
69	1,637	1,713	2,153	685	1,714	1,427
70	1,680	1,756	2,210	703	1,757	1,482
71	1,730	1,808	2,277	724	1,810	1,533
72	1,784	1,866	2,349	747	1,868	1,585
73	1,843	1,926	2,424	772	1,927	1,639
74	1,909	1,995	2,509	799	1,997	1,695
75	1,975	2,065	2,597	826	2,066	1,749
76	2,044	2,136	2,687	854	2,138	1,805
77	2,116	2,210	2,784	886	2,213	1,865
78	2,188	2,287	2,878	914	2,288	1,928
79	2,256	2,358	2,968	944	2,360	1,990
80	2,325	2,431	3,061	972	2,434	2,057
81	2,400	2,509	3,157	1,005	2,512	2,122
82	2,472	2,583	3,251	1,033	2,586	2,185
83	2,547	2,663	3,352	1,067	2,666	2,252
84	2,622	2,741	3,449	1,098	2,745	2,318
85	2,717	2,840	3,575	1,136	2,842	2,402
86	2,796	2,922	3,676	1,170	2,925	2,471
87	2,874	3,005	3,781	1,202	3,009	2,540
88	2,956	3,088	3,886	1,238	3,091	2,611
89	3,036	3,175	3,994	1,273	3,177	2,684
90	3,122	3,262	4,104	1,306	3,265	2,758
91	3,205	3,352	4,216	1,342	3,354	2,834
92	3,292	3,441	4,330	1,378	3,443	2,910
93	3,379	3,533	4,444	1,416	3,535	2,987
94	3,469	3,627	4,562	1,453	3,630	3,065
95	3,560	3,719	4,681	1,489	3,725	3,146
96	3,652	3,817	4,803	1,528	3,820	3,227
97	3,744	3,914	4,926	1,566	3,919	3,309
98	3,839	4,014	5,049	1,608	4,017	3,392
99+	3,936	4,113	5,176	1,648	4,117	3,477

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

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

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

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

Aetna Health Insurance Company

Annual Premiums

For Use in ZIP Codes: 770, 772-773, 775

Female Rates

Rates Effective 2/1/2020

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	5,994	n/a	n/a	n/a	n/a	n/a
65	1,510	1,579	1,986	631	1,580	1,262
66	1,510	1,579	1,986	631	1,580	1,262
67	1,510	1,579	1,986	631	1,580	1,262
68	1,525	1,595	2,006	638	1,596	1,307
69	1,561	1,632	2,053	654	1,633	1,360
70	1,601	1,675	2,108	670	1,676	1,412
71	1,650	1,725	2,171	690	1,726	1,462
72	1,702	1,778	2,239	712	1,781	1,512
73	1,757	1,837	2,312	736	1,838	1,562
74	1,820	1,901	2,392	761	1,903	1,616
75	1,883	1,968	2,476	788	1,970	1,668
76	1,950	2,037	2,563	815	2,038	1,721
77	2,018	2,108	2,653	843	2,111	1,778
78	2,086	2,180	2,743	872	2,182	1,838
79	2,151	2,249	2,829	899	2,250	1,897
80	2,218	2,318	2,919	929	2,321	1,960
81	2,287	2,392	3,010	958	2,395	2,022
82	2,356	2,463	3,098	985	2,466	2,082
83	2,429	2,539	3,195	1,017	2,541	2,147
84	2,500	2,613	3,288	1,045	2,616	2,210
85	2,590	2,708	3,408	1,084	2,711	2,290
86	2,665	2,786	3,504	1,115	2,789	2,356
87	2,740	2,865	3,605	1,147	2,868	2,421
88	2,817	2,944	3,705	1,179	2,947	2,490
89	2,894	3,026	3,808	1,213	3,028	2,559
90	2,976	3,110	3,913	1,245	3,113	2,629
91	3,057	3,195	4,020	1,280	3,197	2,701
92	3,138	3,280	4,127	1,313	3,283	2,774
93	3,221	3,367	4,237	1,349	3,370	2,848
94	3,307	3,457	4,350	1,384	3,461	2,923
95	3,394	3,547	4,462	1,420	3,551	2,999
96	3,481	3,638	4,579	1,457	3,642	3,077
97	3,570	3,732	4,695	1,494	3,736	3,154
98	3,661	3,826	4,813	1,532	3,830	3,235
99+	3,752	3,921	4,934	1,570	3,925	3,315

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	6,658	n/a	n/a	n/a	n/a	n/a
65	1,679	1,754	2,206	701	1,755	1,403
66	1,679	1,754	2,206	701	1,755	1,403
67	1,679	1,754	2,206	701	1,755	1,403
68	1,695	1,773	2,230	709	1,774	1,451
69	1,734	1,814	2,281	726	1,816	1,512
70	1,780	1,860	2,341	744	1,861	1,569
71	1,833	1,916	2,411	766	1,918	1,624
72	1,891	1,977	2,487	792	1,979	1,679
73	1,952	2,041	2,569	817	2,042	1,737
74	2,022	2,113	2,657	846	2,115	1,796
75	2,092	2,187	2,751	875	2,188	1,853
76	2,165	2,263	2,848	905	2,265	1,912
77	2,242	2,341	2,948	938	2,345	1,975
78	2,318	2,421	3,049	969	2,423	2,042
79	2,391	2,499	3,144	1,000	2,500	2,108
80	2,464	2,575	3,241	1,030	2,580	2,179
81	2,542	2,657	3,345	1,065	2,661	2,247
82	2,618	2,736	3,442	1,095	2,739	2,314
83	2,697	2,821	3,550	1,131	2,823	2,385
84	2,778	2,902	3,653	1,162	2,908	2,455
85	2,878	3,008	3,786	1,205	3,011	2,545
86	2,961	3,094	3,894	1,240	3,098	2,617
87	3,046	3,184	4,005	1,274	3,187	2,691
88	3,130	3,271	4,116	1,311	3,275	2,766
89	3,216	3,362	4,232	1,348	3,365	2,843
90	3,306	3,456	4,348	1,383	3,459	2,921
91	3,396	3,550	4,466	1,422	3,552	3,002
92	3,487	3,645	4,587	1,459	3,647	3,082
93	3,579	3,743	4,707	1,499	3,745	3,164
94	3,676	3,840	4,833	1,540	3,844	3,247
95	3,771	3,941	4,959	1,577	3,946	3,333
96	3,869	4,043	5,087	1,619	4,047	3,418
97	3,966	4,146	5,217	1,659	4,151	3,505
98	4,068	4,250	5,348	1,703	4,255	3,594
99+	4,169	4,358	5,482	1,746	4,362	3,684

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

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

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

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

Aetna Health Insurance Company

Annual Premiums

For Use in ZIP Codes: 770, 772-773, 775

Male Rates

Rates Effective 2/1/2020

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	6,893	n/a	n/a	n/a	n/a	n/a
65	1,737	1,816	2,283	726	1,817	1,451
66	1,737	1,816	2,283	726	1,817	1,451
67	1,737	1,816	2,283	726	1,817	1,451
68	1,754	1,834	2,307	734	1,836	1,502
69	1,794	1,876	2,361	752	1,877	1,564
70	1,843	1,926	2,423	771	1,927	1,624
71	1,897	1,983	2,496	795	1,985	1,682
72	1,958	2,045	2,575	819	2,048	1,738
73	2,021	2,113	2,659	846	2,115	1,797
74	2,093	2,187	2,751	876	2,188	1,859
75	2,165	2,263	2,849	905	2,265	1,919
76	2,242	2,342	2,947	937	2,344	1,979
77	2,320	2,423	3,051	970	2,428	2,045
78	2,399	2,507	3,154	1,004	2,508	2,115
79	2,474	2,586	3,255	1,034	2,588	2,182
80	2,550	2,665	3,355	1,068	2,669	2,254
81	2,632	2,751	3,461	1,101	2,754	2,325
82	2,711	2,831	3,563	1,134	2,837	2,395
83	2,794	2,921	3,674	1,170	2,923	2,468
84	2,874	3,006	3,781	1,203	3,008	2,541
85	2,979	3,114	3,918	1,246	3,117	2,633
86	3,066	3,204	4,031	1,282	3,207	2,709
87	3,152	3,294	4,146	1,319	3,298	2,785
88	3,239	3,386	4,261	1,356	3,389	2,864
89	3,330	3,480	4,379	1,394	3,483	2,944
90	3,422	3,575	4,500	1,432	3,579	3,023
91	3,513	3,674	4,623	1,471	3,677	3,106
92	3,609	3,772	4,746	1,510	3,775	3,191
93	3,705	3,874	4,872	1,552	3,877	3,275
94	3,804	3,974	5,001	1,592	3,980	3,361
95	3,902	4,079	5,132	1,633	4,084	3,449
96	4,004	4,183	5,266	1,676	4,189	3,538
97	4,106	4,292	5,399	1,718	4,296	3,627
98	4,210	4,399	5,536	1,762	4,403	3,720
99+	4,315	4,509	5,675	1,805	4,514	3,812

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	7,658	n/a	n/a	n/a	n/a	n/a
65	1,930	2,017	2,537	807	2,019	1,613
66	1,930	2,017	2,537	807	2,019	1,613
67	1,930	2,017	2,537	807	2,019	1,613
68	1,950	2,039	2,565	816	2,041	1,668
69	1,994	2,086	2,622	835	2,088	1,738
70	2,046	2,139	2,692	856	2,140	1,805
71	2,108	2,203	2,774	882	2,204	1,868
72	2,173	2,273	2,861	910	2,275	1,931
73	2,245	2,346	2,953	941	2,348	1,997
74	2,325	2,431	3,057	973	2,432	2,065
75	2,405	2,515	3,164	1,006	2,517	2,131
76	2,490	2,602	3,274	1,040	2,605	2,199
77	2,578	2,692	3,392	1,079	2,696	2,271
78	2,665	2,786	3,505	1,114	2,787	2,349
79	2,748	2,873	3,615	1,150	2,874	2,424
80	2,833	2,961	3,729	1,185	2,965	2,506
81	2,924	3,057	3,846	1,225	3,061	2,585
82	3,011	3,146	3,960	1,258	3,150	2,661
83	3,102	3,244	4,083	1,300	3,248	2,743
84	3,195	3,339	4,201	1,337	3,343	2,823
85	3,310	3,460	4,355	1,384	3,463	2,927
86	3,406	3,559	4,478	1,426	3,563	3,010
87	3,501	3,661	4,606	1,465	3,665	3,094
88	3,601	3,761	4,734	1,508	3,765	3,181
89	3,698	3,867	4,866	1,550	3,870	3,270
90	3,803	3,973	5,000	1,591	3,977	3,359
91	3,905	4,083	5,136	1,635	4,086	3,452
92	4,011	4,192	5,274	1,679	4,194	3,544
93	4,116	4,304	5,414	1,725	4,307	3,638
94	4,226	4,418	5,557	1,770	4,422	3,733
95	4,336	4,531	5,702	1,814	4,537	3,832
96	4,449	4,650	5,850	1,861	4,654	3,932
97	4,561	4,768	6,001	1,908	4,774	4,031
98	4,677	4,890	6,151	1,959	4,894	4,133
99+	4,795	5,010	6,305	2,007	5,016	4,236

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

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

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

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

Aetna Health Insurance Company

Annual Premiums

For Use in: Rest of State

Female Rates

Rates Effective 2/1/2020

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,473	n/a	n/a	n/a	n/a	n/a
65	1,127	1,178	1,482	471	1,179	942
66	1,127	1,178	1,482	471	1,179	942
67	1,127	1,178	1,482	471	1,179	942
68	1,138	1,190	1,497	476	1,191	975
69	1,165	1,218	1,532	488	1,219	1,015
70	1,195	1,250	1,573	500	1,251	1,054
71	1,231	1,287	1,620	515	1,288	1,091
72	1,270	1,327	1,671	531	1,329	1,128
73	1,311	1,371	1,725	549	1,372	1,166
74	1,358	1,419	1,785	568	1,420	1,206
75	1,405	1,469	1,848	588	1,470	1,245
76	1,455	1,520	1,913	608	1,521	1,284
77	1,506	1,573	1,980	629	1,575	1,327
78	1,557	1,627	2,047	651	1,628	1,372
79	1,605	1,678	2,111	671	1,679	1,416
80	1,655	1,730	2,178	693	1,732	1,463
81	1,707	1,785	2,246	715	1,787	1,509
82	1,758	1,838	2,312	735	1,840	1,554
83	1,813	1,895	2,384	759	1,896	1,602
84	1,866	1,950	2,454	780	1,952	1,649
85	1,933	2,021	2,543	809	2,023	1,709
86	1,989	2,079	2,615	832	2,081	1,758
87	2,045	2,138	2,690	856	2,140	1,807
88	2,102	2,197	2,765	880	2,199	1,858
89	2,160	2,258	2,842	905	2,260	1,910
90	2,221	2,321	2,920	929	2,323	1,962
91	2,281	2,384	3,000	955	2,386	2,016
92	2,342	2,448	3,080	980	2,450	2,070
93	2,404	2,513	3,162	1,007	2,515	2,125
94	2,468	2,580	3,246	1,033	2,583	2,181
95	2,533	2,647	3,330	1,060	2,650	2,238
96	2,598	2,715	3,417	1,087	2,718	2,296
97	2,664	2,785	3,504	1,115	2,788	2,354
98	2,732	2,855	3,592	1,143	2,858	2,414
99+	2,800	2,926	3,682	1,172	2,929	2,474

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,969	n/a	n/a	n/a	n/a	n/a
65	1,253	1,309	1,646	523	1,310	1,047
66	1,253	1,309	1,646	523	1,310	1,047
67	1,253	1,309	1,646	523	1,310	1,047
68	1,265	1,323	1,664	529	1,324	1,083
69	1,294	1,354	1,702	542	1,355	1,128
70	1,328	1,388	1,747	555	1,389	1,171
71	1,368	1,430	1,799	572	1,431	1,212
72	1,411	1,475	1,856	591	1,477	1,253
73	1,457	1,523	1,917	610	1,524	1,296
74	1,509	1,577	1,983	631	1,578	1,340
75	1,561	1,632	2,053	653	1,633	1,383
76	1,616	1,689	2,125	675	1,690	1,427
77	1,673	1,747	2,200	700	1,750	1,474
78	1,730	1,807	2,275	723	1,808	1,524
79	1,784	1,865	2,346	746	1,866	1,573
80	1,839	1,922	2,419	769	1,925	1,626
81	1,897	1,983	2,496	795	1,986	1,677
82	1,954	2,042	2,569	817	2,044	1,727
83	2,013	2,105	2,649	844	2,107	1,780
84	2,073	2,166	2,726	867	2,170	1,832
85	2,148	2,245	2,825	899	2,247	1,899
86	2,210	2,309	2,906	925	2,312	1,953
87	2,273	2,376	2,989	951	2,378	2,008
88	2,336	2,441	3,072	978	2,444	2,064
89	2,400	2,509	3,158	1,006	2,511	2,122
90	2,467	2,579	3,245	1,032	2,581	2,180
91	2,534	2,649	3,333	1,061	2,651	2,240
92	2,602	2,720	3,423	1,089	2,722	2,300
93	2,671	2,793	3,513	1,119	2,795	2,361
94	2,743	2,866	3,607	1,149	2,869	2,423
95	2,814	2,941	3,701	1,177	2,945	2,487
96	2,887	3,017	3,796	1,208	3,020	2,551
97	2,960	3,094	3,893	1,238	3,098	2,616
98	3,036	3,172	3,991	1,271	3,175	2,682
99+	3,111	3,252	4,091	1,303	3,255	2,749

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

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

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

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

Aetna Health Insurance Company

Annual Premiums

For Use in: Rest of State

Male Rates

Rates Effective 2/1/2020

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	5,144	n/a	n/a	n/a	n/a	n/a
65	1,296	1,355	1,704	542	1,356	1,083
66	1,296	1,355	1,704	542	1,356	1,083
67	1,296	1,355	1,704	542	1,356	1,083
68	1,309	1,369	1,722	548	1,370	1,121
69	1,339	1,400	1,762	561	1,401	1,167
70	1,375	1,437	1,808	575	1,438	1,212
71	1,416	1,480	1,863	593	1,481	1,255
72	1,461	1,526	1,922	611	1,528	1,297
73	1,508	1,577	1,984	631	1,578	1,341
74	1,562	1,632	2,053	654	1,633	1,387
75	1,616	1,689	2,126	675	1,690	1,432
76	1,673	1,748	2,199	699	1,749	1,477
77	1,731	1,808	2,277	724	1,812	1,526
78	1,790	1,871	2,354	749	1,872	1,578
79	1,846	1,930	2,429	772	1,931	1,628
80	1,903	1,989	2,504	797	1,992	1,682
81	1,964	2,053	2,583	822	2,055	1,735
82	2,023	2,113	2,659	846	2,117	1,787
83	2,085	2,180	2,742	873	2,181	1,842
84	2,145	2,243	2,822	898	2,245	1,896
85	2,223	2,324	2,924	930	2,326	1,965
86	2,288	2,391	3,008	957	2,393	2,022
87	2,352	2,458	3,094	984	2,461	2,078
88	2,417	2,527	3,180	1,012	2,529	2,137
89	2,485	2,597	3,268	1,040	2,599	2,197
90	2,554	2,668	3,358	1,069	2,671	2,256
91	2,622	2,742	3,450	1,098	2,744	2,318
92	2,693	2,815	3,542	1,127	2,817	2,381
93	2,765	2,891	3,636	1,158	2,893	2,444
94	2,839	2,966	3,732	1,188	2,970	2,508
95	2,912	3,044	3,830	1,219	3,048	2,574
96	2,988	3,122	3,930	1,251	3,126	2,640
97	3,064	3,203	4,029	1,282	3,206	2,707
98	3,142	3,283	4,131	1,315	3,286	2,776
99+	3,220	3,365	4,235	1,347	3,369	2,845

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	5,715	n/a	n/a	n/a	n/a	n/a
65	1,440	1,505	1,893	602	1,507	1,204
66	1,440	1,505	1,893	602	1,507	1,204
67	1,440	1,505	1,893	602	1,507	1,204
68	1,455	1,522	1,914	609	1,523	1,245
69	1,488	1,557	1,957	623	1,558	1,297
70	1,527	1,596	2,009	639	1,597	1,347
71	1,573	1,644	2,070	658	1,645	1,394
72	1,622	1,696	2,135	679	1,698	1,441
73	1,675	1,751	2,204	702	1,752	1,490
74	1,735	1,814	2,281	726	1,815	1,541
75	1,795	1,877	2,361	751	1,878	1,590
76	1,858	1,942	2,443	776	1,944	1,641
77	1,924	2,009	2,531	805	2,012	1,695
78	1,989	2,079	2,616	831	2,080	1,753
79	2,051	2,144	2,698	858	2,145	1,809
80	2,114	2,210	2,783	884	2,213	1,870
81	2,182	2,281	2,870	914	2,284	1,929
82	2,247	2,348	2,955	939	2,351	1,986
83	2,315	2,421	3,047	970	2,424	2,047
84	2,384	2,492	3,135	998	2,495	2,107
85	2,470	2,582	3,250	1,033	2,584	2,184
86	2,542	2,656	3,342	1,064	2,659	2,246
87	2,613	2,732	3,437	1,093	2,735	2,309
88	2,687	2,807	3,533	1,125	2,810	2,374
89	2,760	2,886	3,631	1,157	2,888	2,440
90	2,838	2,965	3,731	1,187	2,968	2,507
91	2,914	3,047	3,833	1,220	3,049	2,576
92	2,993	3,128	3,936	1,253	3,130	2,645
93	3,072	3,212	4,040	1,287	3,214	2,715
94	3,154	3,297	4,147	1,321	3,300	2,786
95	3,236	3,381	4,255	1,354	3,386	2,860
96	3,320	3,470	4,366	1,389	3,473	2,934
97	3,404	3,558	4,478	1,424	3,563	3,008
98	3,490	3,649	4,590	1,462	3,652	3,084
99+	3,578	3,739	4,705	1,498	3,743	3,161

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

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

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

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

PREMIUM INFORMATION

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

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 $1,408	$0	$1,408 (Part A Deductible)
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	$0	Up to $176 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 $198 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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare Approved amounts*	$0	$0	$198 (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 $1,408	$1,408 (Part A Deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	$0	Up to $176 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 $198 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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare Approved amounts*	$0	$0	$198 (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 $1,408	$1,408 (Part A Deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 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 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 $198 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 $198 of Medicare-Approved amounts*	$0	$198 (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 $198 of Medicare-Approved amounts*	$0	$198 (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 $198 of Medicare Approved amounts*	$0	$198 (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 $50,000lifetime 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 $2,340 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses are $2,340. 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 $2,340 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,340 DEDUCTIBLE** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$1,408 (Part A Deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 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 $198 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 $2,340 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,340. 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 $2,340 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,340 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 $198 of Medicare-Approved amounts*	$0	$198 (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 $198 of Medicare-Approved amounts*	$0	$198 (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 $2,340 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,340 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $198 of Medicare Approved amounts*	$0	$198 (Part B Deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,340 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,340 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 $1,408	$1,408 (Part A Deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 $198 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 $198 of Medicare-Approved amounts*	$0	$0	$198(Unless Part B deductible has been met)
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 $198 of Medicare-Approved amounts*	$0	$0	$198(Unless Part B deductible has been met)
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 $198 of Medicare Approved amounts*	$0	$0	$198(Unless Part B deductible has been met)
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 $1,408	$1,408 (Part A Deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 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 co-payment/ coinsurance	$0

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

PLAN N

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

*Once you have been billed $198 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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare Approved amounts*	$0	$0	$198 (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