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: 02/2022 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 2022[2]					$6,620[2]	$3,310[2]				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,490 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 2/1/2022

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	6,732	n/a	n/a	n/a	n/a	n/a
65	1,696	1,773	2,338	657	1,843	1,288
66	1,696	1,773	2,338	657	1,843	1,288
67	1,696	1,773	2,338	657	1,843	1,288
68	1,714	1,792	2,362	663	1,861	1,333
69	1,754	1,833	2,417	681	1,905	1,387
70	1,798	1,881	2,482	697	1,955	1,441
71	1,852	1,936	2,557	718	2,013	1,491
72	1,912	1,997	2,636	740	2,077	1,542
73	1,972	2,064	2,722	765	2,145	1,593
74	2,044	2,136	2,817	792	2,220	1,648
75	2,115	2,211	2,916	820	2,298	1,702
76	2,190	2,287	3,018	847	2,377	1,755
77	2,266	2,368	3,122	876	2,462	1,814
78	2,344	2,448	3,229	907	2,545	1,875
79	2,416	2,526	3,330	935	2,624	1,935
80	2,491	2,604	3,436	966	2,708	1,999
81	2,569	2,685	3,543	997	2,793	2,062
82	2,645	2,767	3,647	1,024	2,876	2,124
83	2,730	2,853	3,761	1,057	2,964	2,190
84	2,809	2,935	3,871	1,087	3,051	2,254
85	2,909	3,042	4,011	1,127	3,162	2,336
86	2,995	3,129	4,125	1,159	3,252	2,403
87	3,078	3,219	4,242	1,193	3,345	2,470
88	3,164	3,307	4,362	1,226	3,437	2,539
89	3,251	3,398	4,482	1,261	3,532	2,610
90	3,343	3,493	4,607	1,294	3,631	2,681
91	3,433	3,587	4,733	1,331	3,729	2,755
92	3,526	3,685	4,858	1,365	3,830	2,829
93	3,618	3,783	4,987	1,403	3,930	2,905
94	3,714	3,883	5,121	1,439	4,037	2,982
95	3,812	3,984	5,253	1,477	4,142	3,059
96	3,910	4,087	5,389	1,514	4,248	3,138
97	4,011	4,192	5,528	1,554	4,358	3,217
98	4,111	4,297	5,666	1,593	4,468	3,299
99+	4,214	4,403	5,809	1,633	4,577	3,381

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	7,479	n/a	n/a	n/a	n/a	n/a
65	1,885	1,970	2,597	729	2,048	1,431
66	1,885	1,970	2,597	729	2,048	1,431
67	1,885	1,970	2,597	729	2,048	1,431
68	1,904	1,991	2,625	737	2,069	1,481
69	1,948	2,038	2,684	756	2,117	1,542
70	1,998	2,090	2,756	773	2,171	1,600
71	2,060	2,152	2,838	797	2,236	1,656
72	2,123	2,220	2,927	824	2,309	1,713
73	2,192	2,293	3,023	850	2,383	1,771
74	2,271	2,373	3,129	879	2,466	1,832
75	2,349	2,456	3,239	910	2,553	1,891
76	2,432	2,543	3,353	941	2,641	1,951
77	2,518	2,629	3,471	976	2,735	2,014
78	2,604	2,719	3,589	1,008	2,826	2,082
79	2,684	2,807	3,701	1,040	2,916	2,149
80	2,768	2,893	3,816	1,072	3,008	2,223
81	2,856	2,984	3,938	1,108	3,105	2,293
82	2,941	3,074	4,054	1,139	3,196	2,361
83	3,031	3,168	4,178	1,177	3,294	2,433
84	3,120	3,260	4,300	1,209	3,393	2,504
85	3,233	3,379	4,457	1,253	3,512	2,596
86	3,326	3,475	4,583	1,289	3,614	2,669
87	3,421	3,576	4,715	1,325	3,716	2,744
88	3,515	3,674	4,847	1,363	3,820	2,821
89	3,613	3,776	4,982	1,402	3,925	2,900
90	3,713	3,882	5,119	1,438	4,033	2,980
91	3,814	3,987	5,258	1,478	4,143	3,062
92	3,915	4,094	5,400	1,518	4,255	3,144
93	4,020	4,204	5,541	1,560	4,370	3,227
94	4,129	4,313	5,691	1,601	4,485	3,311
95	4,236	4,427	5,838	1,640	4,603	3,400
96	4,344	4,541	5,988	1,683	4,721	3,487
97	4,454	4,657	6,140	1,726	4,843	3,575
98	4,569	4,774	6,295	1,771	4,962	3,666
99+	4,682	4,895	6,453	1,816	5,087	3,757

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 2/1/2022

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	7,743	n/a	n/a	n/a	n/a	n/a
65	1,951	2,039	2,688	756	2,119	1,481
66	1,951	2,039	2,688	756	2,119	1,481
67	1,951	2,039	2,688	756	2,119	1,481
68	1,970	2,061	2,716	764	2,141	1,532
69	2,015	2,106	2,779	781	2,190	1,595
70	2,069	2,163	2,853	801	2,247	1,656
71	2,132	2,227	2,939	827	2,314	1,715
72	2,199	2,297	3,032	851	2,388	1,773
73	2,269	2,373	3,130	879	2,466	1,833
74	2,350	2,456	3,239	911	2,553	1,896
75	2,432	2,543	3,354	941	2,641	1,958
76	2,518	2,630	3,469	974	2,734	2,019
77	2,605	2,720	3,591	1,009	2,833	2,086
78	2,695	2,817	3,713	1,044	2,927	2,157
79	2,779	2,905	3,831	1,076	3,018	2,226
80	2,864	2,995	3,949	1,111	3,113	2,299
81	2,956	3,090	4,075	1,146	3,212	2,372
82	3,044	3,181	4,194	1,179	3,308	2,443
83	3,137	3,280	4,324	1,217	3,408	2,518
84	3,228	3,377	4,451	1,252	3,509	2,592
85	3,346	3,497	4,612	1,296	3,635	2,685
86	3,444	3,599	4,745	1,333	3,740	2,763
87	3,540	3,698	4,882	1,371	3,847	2,841
88	3,638	3,803	5,016	1,410	3,952	2,921
89	3,740	3,909	5,155	1,450	4,063	3,003
90	3,843	4,016	5,297	1,490	4,175	3,083
91	3,946	4,127	5,442	1,530	4,289	3,168
92	4,054	4,237	5,586	1,570	4,402	3,255
93	4,162	4,352	5,735	1,613	4,521	3,341
94	4,273	4,465	5,888	1,656	4,643	3,428
95	4,382	4,581	6,041	1,699	4,764	3,518
96	4,498	4,699	6,199	1,743	4,886	3,609
97	4,612	4,820	6,356	1,786	5,010	3,700
98	4,729	4,941	6,515	1,833	5,136	3,795
99+	4,847	5,065	6,681	1,877	5,266	3,889

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	8,603	n/a	n/a	n/a	n/a	n/a
65	2,168	2,265	2,986	839	2,356	1,646
66	2,168	2,265	2,986	839	2,356	1,646
67	2,168	2,265	2,986	839	2,356	1,646
68	2,190	2,291	3,019	848	2,381	1,702
69	2,240	2,344	3,087	868	2,436	1,773
70	2,298	2,403	3,169	891	2,496	1,841
71	2,368	2,475	3,266	917	2,571	1,905
72	2,441	2,553	3,369	946	2,655	1,970
73	2,521	2,636	3,476	978	2,738	2,037
74	2,610	2,731	3,598	1,012	2,837	2,106
75	2,701	2,825	3,725	1,047	2,935	2,173
76	2,797	2,924	3,853	1,081	3,039	2,243
77	2,896	3,023	3,992	1,122	3,145	2,317
78	2,995	3,129	4,126	1,158	3,251	2,396
79	3,087	3,227	4,256	1,195	3,353	2,472
80	3,183	3,326	4,391	1,231	3,459	2,555
81	3,284	3,433	4,528	1,274	3,570	2,637
82	3,382	3,534	4,661	1,309	3,674	2,715
83	3,485	3,643	4,807	1,352	3,788	2,798
84	3,587	3,751	4,946	1,391	3,901	2,880
85	3,719	3,886	5,127	1,439	4,039	2,986
86	3,827	3,997	5,272	1,483	4,157	3,070
87	3,933	4,111	5,422	1,524	4,275	3,156
88	4,044	4,225	5,573	1,568	4,393	3,244
89	4,154	4,343	5,727	1,612	4,514	3,335
90	4,272	4,464	5,885	1,654	4,638	3,426
91	4,386	4,587	6,047	1,700	4,765	3,522
92	4,505	4,707	6,210	1,746	4,891	3,615
93	4,624	4,833	6,373	1,793	5,024	3,710
94	4,746	4,962	6,542	1,841	5,158	3,808
95	4,870	5,088	6,712	1,887	5,293	3,909
96	4,997	5,223	6,886	1,936	5,428	4,011
97	5,123	5,355	7,063	1,985	5,569	4,111
98	5,253	5,493	7,240	2,037	5,708	4,216
99+	5,385	5,628	7,421	2,088	5,849	4,320

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

Female Rates

Rates Effective 2/1/2022

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	5,526	n/a	n/a	n/a	n/a	n/a
65	1,393	1,455	1,920	539	1,513	1,057
66	1,393	1,455	1,920	539	1,513	1,057
67	1,393	1,455	1,920	539	1,513	1,057
68	1,407	1,471	1,939	545	1,528	1,095
69	1,440	1,505	1,984	559	1,564	1,139
70	1,476	1,544	2,037	572	1,605	1,183
71	1,520	1,590	2,099	590	1,652	1,224
72	1,570	1,639	2,164	607	1,705	1,266
73	1,619	1,694	2,234	628	1,761	1,308
74	1,678	1,753	2,312	650	1,823	1,353
75	1,736	1,815	2,394	673	1,887	1,397
76	1,797	1,878	2,477	695	1,951	1,441
77	1,860	1,944	2,563	719	2,021	1,489
78	1,924	2,010	2,651	745	2,089	1,539
79	1,983	2,074	2,734	768	2,154	1,588
80	2,045	2,137	2,820	793	2,223	1,641
81	2,109	2,204	2,908	818	2,292	1,693
82	2,171	2,272	2,994	840	2,361	1,744
83	2,241	2,342	3,088	868	2,433	1,797
84	2,306	2,409	3,178	892	2,505	1,850
85	2,388	2,497	3,292	925	2,596	1,917
86	2,459	2,569	3,386	952	2,670	1,972
87	2,527	2,642	3,483	979	2,746	2,027
88	2,597	2,715	3,581	1,007	2,822	2,085
89	2,669	2,790	3,680	1,035	2,900	2,143
90	2,745	2,868	3,782	1,063	2,981	2,201
91	2,818	2,945	3,885	1,092	3,061	2,262
92	2,894	3,025	3,988	1,121	3,144	2,322
93	2,970	3,105	4,094	1,152	3,226	2,385
94	3,049	3,188	4,204	1,181	3,314	2,448
95	3,130	3,270	4,312	1,212	3,400	2,511
96	3,210	3,355	4,424	1,243	3,487	2,576
97	3,292	3,441	4,538	1,276	3,577	2,641
98	3,375	3,528	4,651	1,308	3,667	2,708
99+	3,460	3,615	4,769	1,341	3,758	2,775

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	6,139	n/a	n/a	n/a	n/a	n/a
65	1,548	1,617	2,132	598	1,681	1,175
66	1,548	1,617	2,132	598	1,681	1,175
67	1,548	1,617	2,132	598	1,681	1,175
68	1,563	1,635	2,155	605	1,698	1,216
69	1,599	1,673	2,203	620	1,738	1,266
70	1,640	1,716	2,263	635	1,782	1,313
71	1,691	1,767	2,330	655	1,836	1,360
72	1,742	1,823	2,402	677	1,895	1,406
73	1,800	1,882	2,482	697	1,956	1,454
74	1,865	1,948	2,569	722	2,024	1,504
75	1,928	2,016	2,659	747	2,096	1,552
76	1,997	2,088	2,752	772	2,168	1,602
77	2,067	2,158	2,849	801	2,245	1,653
78	2,137	2,232	2,946	827	2,320	1,709
79	2,203	2,305	3,038	854	2,394	1,764
80	2,273	2,375	3,133	880	2,470	1,825
81	2,344	2,450	3,233	910	2,549	1,882
82	2,415	2,523	3,328	935	2,624	1,938
83	2,488	2,600	3,430	966	2,704	1,998
84	2,561	2,676	3,530	992	2,785	2,056
85	2,654	2,774	3,659	1,029	2,883	2,131
86	2,730	2,852	3,762	1,058	2,967	2,191
87	2,808	2,936	3,871	1,088	3,050	2,253
88	2,885	3,016	3,979	1,119	3,136	2,316
89	2,966	3,100	4,090	1,151	3,222	2,380
90	3,048	3,187	4,202	1,180	3,311	2,446
91	3,131	3,273	4,316	1,213	3,401	2,514
92	3,214	3,361	4,433	1,246	3,493	2,581
93	3,300	3,451	4,549	1,280	3,587	2,649
94	3,389	3,541	4,672	1,315	3,682	2,718
95	3,477	3,634	4,793	1,346	3,779	2,791
96	3,566	3,728	4,916	1,382	3,875	2,862
97	3,656	3,823	5,040	1,417	3,975	2,935
98	3,751	3,919	5,168	1,454	4,073	3,010
99+	3,843	4,018	5,298	1,491	4,176	3,084

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 2/1/2022

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	6,356	n/a	n/a	n/a	n/a	n/a
65	1,602	1,674	2,207	620	1,739	1,216
66	1,602	1,674	2,207	620	1,739	1,216
67	1,602	1,674	2,207	620	1,739	1,216
68	1,617	1,692	2,230	627	1,758	1,257
69	1,654	1,729	2,281	641	1,797	1,309
70	1,698	1,775	2,342	658	1,845	1,360
71	1,750	1,828	2,412	679	1,900	1,408
72	1,805	1,885	2,489	699	1,960	1,455
73	1,862	1,948	2,570	722	2,024	1,505
74	1,929	2,016	2,659	748	2,096	1,557
75	1,997	2,088	2,753	772	2,168	1,607
76	2,067	2,159	2,848	800	2,244	1,658
77	2,138	2,233	2,948	828	2,325	1,713
78	2,212	2,312	3,048	857	2,402	1,771
79	2,281	2,385	3,145	883	2,477	1,827
80	2,351	2,459	3,242	912	2,555	1,888
81	2,427	2,537	3,345	941	2,637	1,947
82	2,499	2,611	3,443	968	2,716	2,005
83	2,575	2,693	3,550	999	2,797	2,067
84	2,650	2,772	3,654	1,027	2,881	2,127
85	2,747	2,871	3,786	1,064	2,984	2,204
86	2,827	2,955	3,895	1,095	3,070	2,268
87	2,906	3,036	4,007	1,125	3,158	2,332
88	2,987	3,122	4,117	1,157	3,244	2,398
89	3,070	3,209	4,232	1,190	3,335	2,465
90	3,155	3,297	4,348	1,223	3,428	2,531
91	3,240	3,388	4,467	1,256	3,521	2,600
92	3,328	3,478	4,586	1,289	3,614	2,672
93	3,417	3,573	4,708	1,324	3,711	2,742
94	3,508	3,665	4,833	1,360	3,812	2,814
95	3,597	3,761	4,959	1,395	3,911	2,888
96	3,693	3,858	5,089	1,431	4,011	2,962
97	3,786	3,957	5,217	1,466	4,113	3,037
98	3,882	4,056	5,348	1,505	4,216	3,115
99+	3,979	4,158	5,485	1,541	4,323	3,192

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	7,062	n/a	n/a	n/a	n/a	n/a
65	1,780	1,859	2,451	689	1,934	1,351
66	1,780	1,859	2,451	689	1,934	1,351
67	1,780	1,859	2,451	689	1,934	1,351
68	1,797	1,881	2,478	696	1,955	1,397
69	1,839	1,924	2,534	713	2,000	1,455
70	1,887	1,972	2,602	732	2,049	1,511
71	1,944	2,032	2,681	752	2,111	1,564
72	2,004	2,096	2,765	777	2,179	1,617
73	2,069	2,164	2,853	803	2,247	1,672
74	2,143	2,242	2,954	831	2,329	1,729
75	2,218	2,319	3,058	859	2,409	1,784
76	2,296	2,400	3,163	888	2,495	1,841
77	2,377	2,482	3,277	921	2,582	1,902
78	2,459	2,569	3,387	950	2,669	1,967
79	2,534	2,649	3,494	981	2,752	2,030
80	2,613	2,730	3,605	1,011	2,839	2,098
81	2,696	2,818	3,717	1,046	2,930	2,165
82	2,776	2,901	3,826	1,075	3,016	2,229
83	2,861	2,991	3,946	1,110	3,110	2,297
84	2,945	3,079	4,060	1,142	3,202	2,364
85	3,053	3,190	4,209	1,181	3,315	2,451
86	3,142	3,281	4,327	1,218	3,412	2,520
87	3,229	3,375	4,451	1,251	3,509	2,591
88	3,320	3,468	4,575	1,287	3,606	2,663
89	3,410	3,565	4,701	1,323	3,706	2,738
90	3,507	3,664	4,831	1,357	3,807	2,813
91	3,600	3,765	4,964	1,396	3,912	2,891
92	3,698	3,864	5,097	1,433	4,015	2,968
93	3,796	3,968	5,232	1,472	4,124	3,046
94	3,896	4,073	5,370	1,511	4,234	3,126
95	3,997	4,177	5,510	1,549	4,345	3,209
96	4,102	4,288	5,653	1,590	4,456	3,292
97	4,205	4,396	5,798	1,629	4,572	3,375
98	4,312	4,509	5,943	1,672	4,686	3,461
99+	4,421	4,620	6,092	1,714	4,802	3,546

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 2/1/2022

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	5,024	n/a	n/a	n/a	n/a	n/a
65	1,266	1,323	1,745	490	1,375	961
66	1,266	1,323	1,745	490	1,375	961
67	1,266	1,323	1,745	490	1,375	961
68	1,279	1,337	1,763	495	1,389	995
69	1,309	1,368	1,804	508	1,422	1,035
70	1,342	1,404	1,852	520	1,459	1,075
71	1,382	1,445	1,908	536	1,502	1,113
72	1,427	1,490	1,967	552	1,550	1,151
73	1,472	1,540	2,031	571	1,601	1,189
74	1,525	1,594	2,102	591	1,657	1,230
75	1,578	1,650	2,176	612	1,715	1,270
76	1,634	1,707	2,252	632	1,774	1,310
77	1,691	1,767	2,330	654	1,837	1,354
78	1,749	1,827	2,410	677	1,899	1,399
79	1,803	1,885	2,485	698	1,958	1,444
80	1,859	1,943	2,564	721	2,021	1,492
81	1,917	2,004	2,644	744	2,084	1,539
82	1,974	2,065	2,722	764	2,146	1,585
83	2,037	2,129	2,807	789	2,212	1,634
84	2,096	2,190	2,889	811	2,277	1,682
85	2,171	2,270	2,993	841	2,360	1,743
86	2,235	2,335	3,078	865	2,427	1,793
87	2,297	2,402	3,166	890	2,496	1,843
88	2,361	2,468	3,255	915	2,565	1,895
89	2,426	2,536	3,345	941	2,636	1,948
90	2,495	2,607	3,438	966	2,710	2,001
91	2,562	2,677	3,532	993	2,783	2,056
92	2,631	2,750	3,625	1,019	2,858	2,111
93	2,700	2,823	3,722	1,047	2,933	2,168
94	2,772	2,898	3,822	1,074	3,013	2,225
95	2,845	2,973	3,920	1,102	3,091	2,283
96	2,918	3,050	4,022	1,130	3,170	2,342
97	2,993	3,128	4,125	1,160	3,252	2,401
98	3,068	3,207	4,228	1,189	3,334	2,462
99+	3,145	3,286	4,335	1,219	3,416	2,523

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	5,581	n/a	n/a	n/a	n/a	n/a
65	1,407	1,470	1,938	544	1,528	1,068
66	1,407	1,470	1,938	544	1,528	1,068
67	1,407	1,470	1,938	544	1,528	1,068
68	1,421	1,486	1,959	550	1,544	1,105
69	1,454	1,521	2,003	564	1,580	1,151
70	1,491	1,560	2,057	577	1,620	1,194
71	1,537	1,606	2,118	595	1,669	1,236
72	1,584	1,657	2,184	615	1,723	1,278
73	1,636	1,711	2,256	634	1,778	1,322
74	1,695	1,771	2,335	656	1,840	1,367
75	1,753	1,833	2,417	679	1,905	1,411
76	1,815	1,898	2,502	702	1,971	1,456
77	1,879	1,962	2,590	728	2,041	1,503
78	1,943	2,029	2,678	752	2,109	1,554
79	2,003	2,095	2,762	776	2,176	1,604
80	2,066	2,159	2,848	800	2,245	1,659
81	2,131	2,227	2,939	827	2,317	1,711
82	2,195	2,294	3,025	850	2,385	1,762
83	2,262	2,364	3,118	878	2,458	1,816
84	2,328	2,433	3,209	902	2,532	1,869
85	2,413	2,522	3,326	935	2,621	1,937
86	2,482	2,593	3,420	962	2,697	1,992
87	2,553	2,669	3,519	989	2,773	2,048
88	2,623	2,742	3,617	1,017	2,851	2,105
89	2,696	2,818	3,718	1,046	2,929	2,164
90	2,771	2,897	3,820	1,073	3,010	2,224
91	2,846	2,975	3,924	1,103	3,092	2,285
92	2,922	3,055	4,030	1,133	3,175	2,346
93	3,000	3,137	4,135	1,164	3,261	2,408
94	3,081	3,219	4,247	1,195	3,347	2,471
95	3,161	3,304	4,357	1,224	3,435	2,537
96	3,242	3,389	4,469	1,256	3,523	2,602
97	3,324	3,475	4,582	1,288	3,614	2,668
98	3,410	3,563	4,698	1,322	3,703	2,736
99+	3,494	3,653	4,816	1,355	3,796	2,804

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 2/1/2022

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	5,778	n/a	n/a	n/a	n/a	n/a
65	1,456	1,522	2,006	564	1,581	1,105
66	1,456	1,522	2,006	564	1,581	1,105
67	1,456	1,522	2,006	564	1,581	1,105
68	1,470	1,538	2,027	570	1,598	1,143
69	1,504	1,572	2,074	583	1,634	1,190
70	1,544	1,614	2,129	598	1,677	1,236
71	1,591	1,662	2,193	617	1,727	1,280
72	1,641	1,714	2,263	635	1,782	1,323
73	1,693	1,771	2,336	656	1,840	1,368
74	1,754	1,833	2,417	680	1,905	1,415
75	1,815	1,898	2,503	702	1,971	1,461
76	1,879	1,963	2,589	727	2,040	1,507
77	1,944	2,030	2,680	753	2,114	1,557
78	2,011	2,102	2,771	779	2,184	1,610
79	2,074	2,168	2,859	803	2,252	1,661
80	2,137	2,235	2,947	829	2,323	1,716
81	2,206	2,306	3,041	855	2,397	1,770
82	2,272	2,374	3,130	880	2,469	1,823
83	2,341	2,448	3,227	908	2,543	1,879
84	2,409	2,520	3,322	934	2,619	1,934
85	2,497	2,610	3,442	967	2,713	2,004
86	2,570	2,686	3,541	995	2,791	2,062
87	2,642	2,760	3,643	1,023	2,871	2,120
88	2,715	2,838	3,743	1,052	2,949	2,180
89	2,791	2,917	3,847	1,082	3,032	2,241
90	2,868	2,997	3,953	1,112	3,116	2,301
91	2,945	3,080	4,061	1,142	3,201	2,364
92	3,025	3,162	4,169	1,172	3,285	2,429
93	3,106	3,248	4,280	1,204	3,374	2,493
94	3,189	3,332	4,394	1,236	3,465	2,558
95	3,270	3,419	4,508	1,268	3,555	2,625
96	3,357	3,507	4,626	1,301	3,646	2,693
97	3,442	3,597	4,743	1,333	3,739	2,761
98	3,529	3,687	4,862	1,368	3,833	2,832
99+	3,617	3,780	4,986	1,401	3,930	2,902

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	6,420	n/a	n/a	n/a	n/a	n/a
65	1,618	1,690	2,228	626	1,758	1,228
66	1,618	1,690	2,228	626	1,758	1,228
67	1,618	1,690	2,228	626	1,758	1,228
68	1,634	1,710	2,253	633	1,777	1,270
69	1,672	1,749	2,304	648	1,818	1,323
70	1,715	1,793	2,365	665	1,863	1,374
71	1,767	1,847	2,437	684	1,919	1,422
72	1,822	1,905	2,514	706	1,981	1,470
73	1,881	1,967	2,594	730	2,043	1,520
74	1,948	2,038	2,685	755	2,117	1,572
75	2,016	2,108	2,780	781	2,190	1,622
76	2,087	2,182	2,875	807	2,268	1,674
77	2,161	2,256	2,979	837	2,347	1,729
78	2,235	2,335	3,079	864	2,426	1,788
79	2,304	2,408	3,176	892	2,502	1,845
80	2,375	2,482	3,277	919	2,581	1,907
81	2,451	2,562	3,379	951	2,664	1,968
82	2,524	2,637	3,478	977	2,742	2,026
83	2,601	2,719	3,587	1,009	2,827	2,088
84	2,677	2,799	3,691	1,038	2,911	2,149
85	2,775	2,900	3,826	1,074	3,014	2,228
86	2,856	2,983	3,934	1,107	3,102	2,291
87	2,935	3,068	4,046	1,137	3,190	2,355
88	3,018	3,153	4,159	1,170	3,278	2,421
89	3,100	3,241	4,274	1,203	3,369	2,489
90	3,188	3,331	4,392	1,234	3,461	2,557
91	3,273	3,423	4,513	1,269	3,556	2,628
92	3,362	3,513	4,634	1,303	3,650	2,698
93	3,451	3,607	4,756	1,338	3,749	2,769
94	3,542	3,703	4,882	1,374	3,849	2,842
95	3,634	3,797	5,009	1,408	3,950	2,917
96	3,729	3,898	5,139	1,445	4,051	2,993
97	3,823	3,996	5,271	1,481	4,156	3,068
98	3,920	4,099	5,403	1,520	4,260	3,146
99+	4,019	4,200	5,538	1,558	4,365	3,224

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.

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 $1,556	$0	$1,556 (Part A Deductible)
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	$0	Up to $194.50 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 $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$0	$233 (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 $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	$0	Up to $194.50 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 $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$0	$233 (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 $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 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 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 $233 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 $233 of Medicare-Approved amounts*	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$233 (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 Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 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 $2,490 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses are $2,490. 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 $2,490 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 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 $233 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 $2,490 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,490. 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 $2,490 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,490 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 $233 of Medicare-Approved amounts*	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$233 (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 $2,490 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $233 of Medicare Approved amounts*	$0	$233 (Part B Deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,490 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,490 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 $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited 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 $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233(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 $233 of Medicare-Approved amounts*	$0	$0	$233(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 $233 of Medicare Approved amounts*	$0	$0	$233(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 $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 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 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 $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare Approved amounts*	$	$0	$233 (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