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: 02/2026 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 2026[2]					**$8,000**[2]	**$4,000**[2]				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,950** 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 2/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65 (ESRD/ALS)	2,597	2,543	8,383	1,313	6,609	4,539
Under 65 (non ESRD/ALS)	11,468	n/a	n/a	n/a	n/a	n/a
65	2,597	2,543	4,192	657	3,304	2,269
66	2,597	2,543	4,192	657	3,304	2,269
67	2,597	2,543	4,192	657	3,304	2,269
68	2,624	2,570	4,237	663	3,338	2,349
69	2,684	2,630	4,334	681	3,418	2,444
70	2,752	2,700	4,450	697	3,505	2,539
71	2,834	2,779	4,585	718	3,609	2,629
72	2,928	2,865	4,726	740	3,724	2,718
73	3,019	2,961	4,882	765	3,847	2,809
74	3,130	3,063	5,050	792	3,981	2,905
75	3,237	3,173	5,230	820	4,122	2,998
76	3,351	3,283	5,411	847	4,263	3,093
77	3,469	3,397	5,601	876	4,415	3,196
78	3,587	3,512	5,791	907	4,563	3,304
79	3,697	3,625	5,971	935	4,706	3,409
80	3,814	3,737	6,164	966	4,859	3,523
81	3,933	3,854	6,353	997	5,008	3,635
82	4,048	3,972	6,542	1,024	5,159	3,743
83	4,179	4,095	6,747	1,057	5,316	3,858
84	4,301	4,210	6,943	1,087	5,473	3,972
85	4,454	4,366	7,193	1,127	5,670	4,116
86	4,585	4,489	7,397	1,159	5,833	4,233
87	4,713	4,619	7,609	1,193	5,999	4,351
88	4,843	4,745	7,824	1,226	6,165	4,474
89	4,978	4,876	8,037	1,261	6,334	4,602
90	5,119	5,014	8,264	1,294	6,511	4,725
91	5,255	5,148	8,488	1,331	6,688	4,855
92	5,395	5,289	8,711	1,365	6,869	4,983
93	5,538	5,428	8,945	1,403	7,048	5,120
94	5,684	5,572	9,186	1,439	7,241	5,254
95	5,836	5,718	9,420	1,477	7,429	5,391
96	5,986	5,865	9,668	1,514	7,618	5,532
97	6,137	6,017	9,912	1,554	7,815	5,670
98	6,294	6,168	10,160	1,593	8,012	5,813
99+	6,452	6,318	10,417	1,633	8,210	5,958

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65 (ESRD/ALS)	2,886	2,826	9,317	1,458	7,343	5,041
Under 65 (non ESRD/ALS)	12,739	n/a	n/a	n/a	n/a	n/a
65	2,886	2,826	4,658	729	3,672	2,521
66	2,886	2,826	4,658	729	3,672	2,521
67	2,886	2,826	4,658	729	3,672	2,521
68	2,915	2,858	4,707	737	3,709	2,610
69	2,982	2,925	4,812	756	3,798	2,718
70	3,058	2,999	4,945	773	3,891	2,819
71	3,153	3,090	5,089	797	4,009	2,919
72	3,248	3,187	5,247	824	4,143	3,016
73	3,357	3,290	5,422	850	4,272	3,124
74	3,479	3,405	5,611	879	4,422	3,227
75	3,595	3,526	5,808	910	4,579	3,330
76	3,725	3,650	6,011	941	4,737	3,440
77	3,854	3,773	6,223	976	4,904	3,548
78	3,985	3,902	6,436	1,008	5,068	3,669
79	4,107	4,029	6,636	1,040	5,230	3,786
80	4,238	4,153	6,845	1,072	5,394	3,918
81	4,370	4,281	7,063	1,108	5,568	4,040
82	4,504	4,411	7,268	1,139	5,733	4,158
83	4,640	4,547	7,493	1,177	5,907	4,288
84	4,776	4,679	7,712	1,209	6,085	4,413
85	4,949	4,849	7,993	1,253	6,299	4,573
86	5,089	4,985	8,220	1,289	6,482	4,705
87	5,237	5,132	8,457	1,325	6,665	4,837
88	5,380	5,273	8,694	1,363	6,851	4,973
89	5,530	5,419	8,935	1,402	7,038	5,111
90	5,683	5,570	9,180	1,438	7,235	5,253
91	5,837	5,722	9,431	1,478	7,430	5,396
92	5,992	5,875	9,686	1,518	7,630	5,542
93	6,153	6,033	9,937	1,560	7,836	5,687
94	6,319	6,191	10,208	1,601	8,044	5,836
95	6,484	6,353	10,471	1,640	8,254	5,990
96	6,649	6,516	10,740	1,683	8,467	6,144
97	6,818	6,683	11,012	1,726	8,686	6,299
98	6,995	6,851	11,290	1,771	8,898	6,459
99+	7,166	7,024	11,575	1,816	9,124	6,621

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

To calculate a household discount:

Annual premium **x** modal factor**= modal premium** (round to nearest whole cent)
Modal premium **x** .93 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

Aetna Health Insurance Company
Annual premiums
For use in ZIP Codes: 770, 772-773, 775
Male rates
Rates effective 2/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65 (ESRD/ALS)	2,987	2,927	9,643	1,512	7,602	5,221
Under 65 (non ESRD/ALS)	13,188	n/a	n/a	n/a	n/a	n/a
65	2,987	2,927	4,821	756	3,802	2,610
66	2,987	2,927	4,821	756	3,802	2,610
67	2,987	2,927	4,821	756	3,802	2,610
68	3,016	2,957	4,872	764	3,842	2,697
69	3,083	3,022	4,983	781	3,928	2,810
70	3,166	3,103	5,116	801	4,031	2,919
71	3,264	3,197	5,269	827	4,149	3,023
72	3,367	3,296	5,439	851	4,281	3,126
73	3,472	3,405	5,612	879	4,422	3,231
74	3,597	3,526	5,808	911	4,579	3,341
75	3,725	3,650	6,014	941	4,737	3,451
76	3,854	3,775	6,222	974	4,903	3,558
77	3,987	3,903	6,440	1,009	5,080	3,678
78	4,123	4,041	6,661	1,044	5,247	3,802
79	4,253	4,170	6,870	1,076	5,411	3,921
80	4,384	4,297	7,082	1,111	5,584	4,052
81	4,527	4,434	7,308	1,146	5,762	4,179
82	4,661	4,565	7,523	1,179	5,932	4,304
83	4,801	4,707	7,755	1,217	6,112	4,437
84	4,942	4,845	7,984	1,252	6,293	4,568
85	5,123	5,018	8,272	1,296	6,520	4,732
86	5,272	5,166	8,510	1,333	6,708	4,868
87	5,420	5,306	8,756	1,371	6,901	5,006
88	5,570	5,455	8,995	1,410	7,087	5,148
89	5,724	5,611	9,245	1,450	7,286	5,290
90	5,884	5,763	9,498	1,490	7,491	5,432
91	6,041	5,921	9,758	1,530	7,693	5,584
92	6,206	6,081	10,017	1,570	7,895	5,735
93	6,372	6,246	10,286	1,613	8,108	5,887
94	6,542	6,408	10,559	1,656	8,327	6,041
95	6,708	6,574	10,833	1,699	8,544	6,199
96	6,885	6,744	11,115	1,743	8,764	6,358
97	7,060	6,917	11,399	1,786	8,986	6,519
98	7,239	7,090	11,683	1,833	9,213	6,687
99+	7,420	7,268	11,982	1,877	9,444	6,853

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65 (ESRD/ALS)	3,319	3,250	10,705	1,678	8,450	5,800
Under 65 (non ESRD/ALS)	14,653	n/a	n/a	n/a	n/a	n/a
65	3,319	3,250	5,352	839	4,225	2,900
66	3,319	3,250	5,352	839	4,225	2,900
67	3,319	3,250	5,352	839	4,225	2,900
68	3,351	3,288	5,412	848	4,271	2,998
69	3,429	3,363	5,536	868	4,367	3,126
70	3,520	3,448	5,683	891	4,478	3,244
71	3,625	3,550	5,856	917	4,611	3,358
72	3,736	3,662	6,042	946	4,761	3,471
73	3,859	3,783	6,234	978	4,910	3,587
74	3,996	3,918	6,451	1,012	5,088	3,713
75	4,137	4,055	6,683	1,047	5,264	3,831
76	4,283	4,194	6,910	1,081	5,450	3,953
77	4,434	4,338	7,157	1,122	5,640	4,083
78	4,585	4,489	7,398	1,158	5,832	4,222
79	4,725	4,630	7,633	1,195	6,011	4,356
80	4,871	4,772	7,877	1,231	6,204	4,505
81	5,028	4,926	8,119	1,274	6,404	4,647
82	5,176	5,071	8,356	1,309	6,590	4,785
83	5,335	5,229	8,620	1,352	6,792	4,931
84	5,493	5,384	8,871	1,391	6,995	5,076
85	5,692	5,576	9,195	1,439	7,244	5,260
86	5,858	5,735	9,454	1,483	7,454	5,411
87	6,021	5,900	9,724	1,524	7,667	5,562
88	6,191	6,064	9,995	1,568	7,878	5,719
89	6,358	6,232	10,271	1,612	8,096	5,877
90	6,541	6,407	10,555	1,654	8,316	6,037
91	6,712	6,582	10,846	1,700	8,545	6,207
92	6,896	6,755	11,137	1,746	8,770	6,372
93	7,079	6,937	11,430	1,793	9,010	6,538
94	7,265	7,119	11,733	1,841	9,250	6,711
95	7,454	7,302	12,037	1,887	9,494	6,889
96	7,647	7,495	12,349	1,936	9,735	7,069
97	7,842	7,685	12,668	1,985	9,988	7,245
98	8,040	7,882	12,985	2,037	10,239	7,430
99+	8,242	8,076	13,309	2,088	10,490	7,613

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

To calculate a household discount:
Annual premium **x** modal factor**= modal premium** (round to nearest whole cent)
Modal premium **x** .93 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

Aetna Health Insurance Company
Annual premiums
For use in ZIP Codes: 750-752, 760-761, 774, 776-777, 782, 784, 793-794
Female rates
Rates effective 2/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65 (ESRD/ALS)	2,132	2,088	6,882	1,078	5,425	3,726
Under 65 (non ESRD/ALS)	9,414	n/a	n/a	n/a	n/a	n/a
65	2,132	2,088	3,441	539	2,713	1,862
66	2,132	2,088	3,441	539	2,713	1,862
67	2,132	2,088	3,441	539	2,713	1,862
68	2,154	2,110	3,478	545	2,740	1,928
69	2,203	2,159	3,557	559	2,806	2,006
70	2,259	2,217	3,653	572	2,878	2,085
71	2,327	2,281	3,764	590	2,962	2,158
72	2,404	2,352	3,880	607	3,057	2,231
73	2,478	2,431	4,007	628	3,158	2,306
74	2,570	2,515	4,146	650	3,268	2,385
75	2,658	2,605	4,293	673	3,384	2,461
76	2,751	2,695	4,442	695	3,499	2,539
77	2,848	2,789	4,598	719	3,625	2,624
78	2,945	2,883	4,754	745	3,746	2,713
79	3,035	2,976	4,902	768	3,863	2,798
80	3,131	3,068	5,060	793	3,989	2,892
81	3,229	3,164	5,215	818	4,111	2,984
82	3,323	3,260	5,370	840	4,235	3,072
83	3,431	3,362	5,539	868	4,364	3,167
84	3,531	3,456	5,699	892	4,492	3,260
85	3,656	3,584	5,905	925	4,654	3,379
86	3,764	3,685	6,072	952	4,788	3,475
87	3,869	3,792	6,246	979	4,925	3,572
88	3,975	3,895	6,423	1,007	5,061	3,673
89	4,087	4,003	6,598	1,035	5,200	3,777
90	4,202	4,116	6,784	1,063	5,345	3,879
91	4,314	4,226	6,967	1,092	5,490	3,985
92	4,429	4,342	7,151	1,121	5,639	4,091
93	4,546	4,456	7,343	1,152	5,786	4,203
94	4,666	4,574	7,541	1,181	5,944	4,313
95	4,791	4,694	7,733	1,212	6,098	4,425
96	4,914	4,815	7,937	1,243	6,254	4,541
97	5,038	4,939	8,137	1,276	6,415	4,654
98	5,167	5,063	8,340	1,308	6,577	4,772
99+	5,297	5,187	8,551	1,341	6,740	4,891

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65 (ESRD/ALS)	2,369	2,320	7,648	1,197	6,028	4,138
Under 65 (non ESRD/ALS)	10,458	n/a	n/a	n/a	n/a	n/a
65	2,369	2,320	3,824	598	3,014	2,069
66	2,369	2,320	3,824	598	3,014	2,069
67	2,369	2,320	3,824	598	3,014	2,069
68	2,393	2,346	3,864	605	3,045	2,143
69	2,448	2,401	3,950	620	3,117	2,231
70	2,510	2,462	4,059	635	3,194	2,314
71	2,588	2,537	4,178	655	3,291	2,396
72	2,666	2,616	4,308	677	3,401	2,476
73	2,756	2,701	4,451	697	3,507	2,564
74	2,856	2,795	4,606	722	3,630	2,649
75	2,951	2,894	4,767	747	3,759	2,734
76	3,058	2,996	4,935	772	3,889	2,824
77	3,164	3,098	5,108	801	4,026	2,913
78	3,271	3,203	5,283	827	4,160	3,012
79	3,372	3,308	5,447	854	4,293	3,108
80	3,479	3,409	5,619	880	4,428	3,216
81	3,587	3,515	5,798	910	4,571	3,317
82	3,697	3,621	5,966	935	4,706	3,413
83	3,809	3,732	6,151	966	4,849	3,520
84	3,920	3,841	6,331	992	4,995	3,622
85	4,062	3,981	6,562	1,029	5,171	3,754
86	4,178	4,092	6,747	1,058	5,321	3,862
87	4,299	4,213	6,942	1,088	5,471	3,971
88	4,417	4,329	7,137	1,119	5,624	4,082
89	4,540	4,448	7,335	1,151	5,777	4,195
90	4,665	4,573	7,536	1,180	5,939	4,312
91	4,792	4,697	7,742	1,213	6,100	4,430
92	4,919	4,822	7,951	1,246	6,263	4,550
93	5,051	4,952	8,158	1,280	6,433	4,668
94	5,188	5,082	8,380	1,315	6,603	4,791
95	5,323	5,215	8,595	1,346	6,776	4,917
96	5,458	5,349	8,817	1,382	6,951	5,044
97	5,597	5,486	9,040	1,417	7,130	5,171
98	5,742	5,624	9,268	1,454	7,304	5,302
99+	5,883	5,766	9,502	1,491	7,490	5,435

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

To calculate a household discount:
Annual premium **x** modal factor**= modal premium** (round to nearest whole cent)
Modal premium **x** .93 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

Aetna Health Insurance Company
Annual premiums
For use in ZIP Codes: 750-752, 760-761, 774, 776-777, 782, 784, 793-794
Male rates
Rates effective 2/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65 (ESRD/ALS)	2,452	2,402	7,916	1,241	6,240	4,286
Under 65 (non ESRD/ALS)	10,826	n/a	n/a	n/a	n/a	n/a
65	2,452	2,402	3,958	620	3,121	2,143
66	2,452	2,402	3,958	620	3,121	2,143
67	2,452	2,402	3,958	620	3,121	2,143
68	2,476	2,428	4,000	627	3,154	2,214
69	2,531	2,481	4,091	641	3,224	2,307
70	2,599	2,548	4,200	658	3,309	2,396
71	2,680	2,625	4,325	679	3,406	2,482
72	2,764	2,706	4,465	699	3,515	2,566
73	2,850	2,795	4,607	722	3,630	2,652
74	2,952	2,894	4,767	748	3,759	2,742
75	3,058	2,996	4,937	772	3,889	2,833
76	3,164	3,099	5,107	800	4,025	2,921
77	3,273	3,204	5,287	828	4,170	3,020
78	3,385	3,318	5,468	857	4,308	3,121
79	3,491	3,423	5,640	883	4,442	3,219
80	3,599	3,528	5,814	912	4,584	3,326
81	3,716	3,640	5,999	941	4,730	3,431
82	3,826	3,748	6,175	968	4,870	3,533
83	3,941	3,864	6,366	999	5,017	3,642
84	4,057	3,978	6,554	1,027	5,166	3,750
85	4,205	4,120	6,790	1,064	5,353	3,884
86	4,327	4,241	6,986	1,095	5,507	3,996
87	4,450	4,356	7,187	1,125	5,665	4,110
88	4,573	4,478	7,384	1,157	5,818	4,226
89	4,699	4,606	7,589	1,190	5,981	4,343
90	4,830	4,731	7,797	1,223	6,149	4,459
91	4,959	4,861	8,010	1,256	6,315	4,584
92	5,094	4,992	8,223	1,289	6,481	4,708
93	5,231	5,127	8,444	1,324	6,656	4,832
94	5,370	5,260	8,668	1,360	6,835	4,959
95	5,507	5,397	8,892	1,395	7,014	5,089
96	5,652	5,536	9,125	1,431	7,194	5,220
97	5,796	5,678	9,358	1,466	7,377	5,352
98	5,942	5,820	9,591	1,505	7,563	5,489
99+	6,091	5,966	9,836	1,541	7,753	5,625

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65 (ESRD/ALS)	2,725	2,668	8,788	1,377	6,937	4,761
Under 65 (non ESRD/ALS)	12,029	n/a	n/a	n/a	n/a	n/a
65	2,725	2,668	4,393	689	3,468	2,380
66	2,725	2,668	4,393	689	3,468	2,380
67	2,725	2,668	4,393	689	3,468	2,380
68	2,751	2,699	4,443	696	3,506	2,461
69	2,815	2,761	4,544	713	3,585	2,566
70	2,890	2,830	4,665	732	3,676	2,663
71	2,976	2,914	4,807	752	3,785	2,757
72	3,067	3,006	4,960	777	3,908	2,849
73	3,168	3,105	5,117	803	4,030	2,945
74	3,280	3,216	5,295	831	4,177	3,048
75	3,396	3,329	5,486	859	4,321	3,145
76	3,516	3,443	5,673	888	4,474	3,245
77	3,640	3,561	5,875	921	4,630	3,352
78	3,764	3,685	6,073	950	4,787	3,466
79	3,879	3,801	6,266	981	4,935	3,576
80	3,999	3,917	6,466	1,011	5,093	3,698
81	4,127	4,044	6,665	1,046	5,257	3,815
82	4,249	4,162	6,860	1,075	5,410	3,928
83	4,379	4,292	7,076	1,110	5,576	4,048
84	4,509	4,420	7,282	1,142	5,742	4,167
85	4,673	4,577	7,548	1,181	5,947	4,318
86	4,809	4,708	7,761	1,218	6,119	4,442
87	4,942	4,843	7,983	1,251	6,294	4,566
88	5,082	4,978	8,205	1,287	6,467	4,695
89	5,220	5,116	8,432	1,323	6,646	4,825
90	5,369	5,259	8,665	1,357	6,827	4,956
91	5,510	5,403	8,903	1,396	7,015	5,095
92	5,661	5,545	9,142	1,433	7,200	5,231
93	5,811	5,695	9,383	1,472	7,396	5,367
94	5,964	5,844	9,632	1,511	7,593	5,509
95	6,119	5,994	9,881	1,549	7,794	5,655
96	6,278	6,152	10,138	1,590	7,992	5,803
97	6,437	6,309	10,399	1,629	8,199	5,948
98	6,600	6,470	10,659	1,672	8,405	6,100
99+	6,766	6,630	10,925	1,714	8,611	6,249

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**

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Aetna Health Insurance Company
Annual premiums
For use in ZIP Codes: Rest of State
Female rates
Rates effective 2/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65 (ESRD/ALS)	1,938	1,898	6,256	980	4,932	3,387
Under 65 (non ESRD/ALS)	8,558	---	---	---	---	---
65	1,938	1,898	3,128	490	2,466	1,693
66	1,938	1,898	3,128	490	2,466	1,693
67	1,938	1,898	3,128	490	2,466	1,693
68	1,958	1,918	3,162	495	2,491	1,753
69	2,003	1,963	3,234	508	2,551	1,824
70	2,054	2,015	3,321	520	2,616	1,895
71	2,115	2,074	3,422	536	2,693	1,962
72	2,185	2,138	3,527	552	2,779	2,028
73	2,253	2,210	3,643	571	2,871	2,096
74	2,336	2,286	3,769	591	2,971	2,168
75	2,416	2,368	3,903	612	3,076	2,237
76	2,501	2,450	4,038	632	3,181	2,308
77	2,589	2,535	4,180	654	3,295	2,385
78	2,677	2,621	4,322	677	3,405	2,466
79	2,759	2,705	4,456	698	3,512	2,544
80	2,846	2,789	4,600	721	3,626	2,629
81	2,935	2,876	4,741	744	3,737	2,713
82	3,021	2,964	4,882	764	3,850	2,793
83	3,119	3,056	5,035	789	3,967	2,879
84	3,210	3,142	5,181	811	4,084	2,964
85	3,324	3,258	5,368	841	4,231	3,072
86	3,422	3,350	5,520	865	4,353	3,159
87	3,517	3,447	5,678	890	4,477	3,247
88	3,614	3,541	5,839	915	4,601	3,339
89	3,715	3,639	5,998	941	4,727	3,434
90	3,820	3,742	6,167	966	4,859	3,526
91	3,922	3,842	6,334	993	4,991	3,623
92	4,026	3,947	6,501	1,019	5,126	3,719
93	4,133	4,051	6,675	1,047	5,260	3,821
94	4,242	4,158	6,855	1,074	5,404	3,921
95	4,355	4,267	7,030	1,102	5,544	4,023
96	4,467	4,377	7,215	1,130	5,685	4,128
97	4,580	4,490	7,397	1,160	5,832	4,231
98	4,697	4,603	7,582	1,189	5,979	4,338
99+	4,815	4,715	7,774	1,219	6,127	4,446

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65 (ESRD/ALS)	2,154	2,109	6,953	1,088	5,480	3,762
Under 65 (non ESRD/ALS)	9,507	---	---	---	---	---
65	2,154	2,109	3,476	544	2,740	1,881
66	2,154	2,109	3,476	544	2,740	1,881
67	2,154	2,109	3,476	544	2,740	1,881
68	2,175	2,133	3,513	550	2,768	1,948
69	2,225	2,183	3,591	564	2,834	2,028
70	2,282	2,238	3,690	577	2,904	2,104
71	2,353	2,306	3,798	595	2,992	2,178
72	2,424	2,378	3,916	615	3,092	2,251
73	2,505	2,455	4,046	634	3,188	2,331
74	2,596	2,541	4,187	656	3,300	2,408
75	2,683	2,631	4,334	679	3,417	2,485
76	2,780	2,724	4,486	702	3,535	2,567
77	2,876	2,816	4,644	728	3,660	2,648
78	2,974	2,912	4,803	752	3,782	2,738
79	3,065	3,007	4,952	776	3,903	2,825
80	3,163	3,099	5,108	800	4,025	2,924
81	3,261	3,195	5,271	827	4,155	3,015
82	3,361	3,292	5,424	850	4,278	3,103
83	3,463	3,393	5,592	878	4,408	3,200
84	3,564	3,492	5,755	902	4,541	3,293
85	3,693	3,619	5,965	935	4,701	3,413
86	3,798	3,720	6,134	962	4,837	3,511
87	3,908	3,830	6,311	989	4,974	3,610
88	4,015	3,935	6,488	1,017	5,113	3,711
89	4,127	4,044	6,668	1,046	5,252	3,814
90	4,241	4,157	6,851	1,073	5,399	3,920
91	4,356	4,270	7,038	1,103	5,545	4,027
92	4,472	4,384	7,228	1,133	5,694	4,136
93	4,592	4,502	7,416	1,164	5,848	4,244
94	4,716	4,620	7,618	1,195	6,003	4,355
95	4,839	4,741	7,814	1,224	6,160	4,470
96	4,962	4,863	8,015	1,256	6,319	4,585
97	5,088	4,987	8,218	1,288	6,482	4,701
98	5,220	5,113	8,425	1,322	6,640	4,820
99+	5,348	5,242	8,638	1,355	6,809	4,941

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**

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Aetna Health Insurance Company
Annual premiums
For use in ZIP Codes: Rest of State
Male rates
Rates effective 2/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65 (ESRD/ALS)	2,229	2,184	7,196	1,128	5,673	3,896
Under 65 (non ESRD/ALS)	9,842	---	---	---	---	---
65	2,229	2,184	3,598	564	2,837	1,948
66	2,229	2,184	3,598	564	2,837	1,948
67	2,229	2,184	3,598	564	2,837	1,948
68	2,251	2,207	3,636	570	2,867	2,013
69	2,301	2,255	3,719	583	2,931	2,097
70	2,363	2,316	3,818	598	3,008	2,178
71	2,436	2,386	3,932	617	3,096	2,256
72	2,513	2,460	4,059	635	3,195	2,333
73	2,591	2,541	4,188	656	3,300	2,411
74	2,684	2,631	4,334	680	3,417	2,493
75	2,780	2,724	4,488	702	3,535	2,575
76	2,876	2,817	4,643	727	3,659	2,655
77	2,975	2,913	4,806	753	3,791	2,745
78	3,077	3,016	4,971	779	3,916	2,837
79	3,174	3,112	5,127	803	4,038	2,926
80	3,272	3,207	5,285	829	4,167	3,024
81	3,378	3,309	5,454	855	4,300	3,119
82	3,478	3,407	5,614	880	4,427	3,212
83	3,583	3,513	5,787	908	4,561	3,311
84	3,688	3,616	5,958	934	4,696	3,409
85	3,823	3,745	6,173	967	4,866	3,531
86	3,934	3,855	6,351	995	5,006	3,633
87	4,045	3,960	6,534	1,023	5,150	3,736
88	4,157	4,071	6,713	1,052	5,289	3,842
89	4,272	4,187	6,899	1,082	5,437	3,948
90	4,391	4,301	7,088	1,112	5,590	4,054
91	4,508	4,419	7,282	1,142	5,741	4,167
92	4,631	4,538	7,475	1,172	5,892	4,280
93	4,755	4,661	7,676	1,204	6,051	4,393
94	4,882	4,782	7,880	1,236	6,214	4,508
95	5,006	4,906	8,084	1,268	6,376	4,626
96	5,138	5,033	8,295	1,301	6,540	4,745
97	5,269	5,162	8,507	1,333	6,706	4,865
98	5,402	5,291	8,719	1,368	6,875	4,990
99+	5,537	5,424	8,942	1,401	7,048	5,114

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65 (ESRD/ALS)	2,477	2,425	7,989	1,252	6,306	4,328
Under 65 (non ESRD/ALS)	10,935	---	---	---	---	---
65	2,477	2,425	3,994	626	3,153	2,164
66	2,477	2,425	3,994	626	3,153	2,164
67	2,477	2,425	3,994	626	3,153	2,164
68	2,501	2,454	4,039	633	3,187	2,237
69	2,559	2,510	4,131	648	3,259	2,333
70	2,627	2,573	4,241	665	3,342	2,421
71	2,705	2,649	4,370	684	3,441	2,506
72	2,788	2,733	4,509	706	3,553	2,590
73	2,880	2,823	4,652	730	3,664	2,677
74	2,982	2,924	4,814	755	3,797	2,771
75	3,087	3,026	4,987	781	3,928	2,859
76	3,196	3,130	5,157	807	4,067	2,950
77	3,309	3,237	5,341	837	4,209	3,047
78	3,422	3,350	5,521	864	4,352	3,151
79	3,526	3,455	5,696	892	4,486	3,251
80	3,635	3,561	5,878	919	4,630	3,362
81	3,752	3,676	6,059	951	4,779	3,468
82	3,863	3,784	6,236	977	4,918	3,571
83	3,981	3,902	6,433	1,009	5,069	3,680
84	4,099	4,018	6,620	1,038	5,220	3,788
85	4,248	4,161	6,862	1,074	5,406	3,925
86	4,372	4,280	7,055	1,107	5,563	4,038
87	4,493	4,403	7,257	1,137	5,722	4,151
88	4,620	4,525	7,459	1,170	5,879	4,268
89	4,745	4,651	7,665	1,203	6,042	4,386
90	4,881	4,781	7,877	1,234	6,206	4,505
91	5,009	4,912	8,094	1,269	6,377	4,632
92	5,146	5,041	8,311	1,303	6,545	4,755
93	5,283	5,177	8,530	1,338	6,724	4,879
94	5,422	5,313	8,756	1,374	6,903	5,008
95	5,563	5,449	8,983	1,408	7,085	5,141
96	5,707	5,593	9,216	1,445	7,265	5,275
97	5,852	5,735	9,454	1,481	7,454	5,407
98	6,000	5,882	9,690	1,520	7,641	5,545
99+	6,151	6,027	9,932	1,558	7,828	5,681

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**

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

If applying during Open Enrollment or Guaranteed Issue periods, 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 $1,736	$0	$1,736 (Part A Deductible)
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after While using 60 lifetime reserve days	All but $868 a day	$868 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 $217 a day	$0	Up to $217 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 $283 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 $283 of Medicare-Approved amounts*	$0	$0	$283 (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 $283 of Medicare-Approved amounts*	$0	$0	$283 (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 $283 of Medicare-Approved amounts*	$0	$0	$283 (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 $1,736	$1,736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after While using 60 lifetime reserve days	All but $868 a day	$868 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 $217 a day	$0	Up to $217 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 $283 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 $283 of Medicare-Approved amounts*	$0	$0	$283 (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 $283 of Medicare-Approved amounts*	$0	$0	$283 (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 $283 of Medicare-Approved amounts*	$0	$0	$283 (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 $1,736	$1,736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after While using 60 lifetime reserve days	All but $868 a day	$868 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 $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN F

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

*Once you have been billed $283 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 $283 of Medicare-Approved amounts*	$0	$283 (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 $283 of Medicare-Approved amounts*	$0	$283 (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 $283 of Medicare-Approved amounts*	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE PLAN F

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

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

****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,950 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,950. 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 $2,950 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,950 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after While using 60 lifetime reserve days	All but $868 a day	$868 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 $217 a day	Up to $217 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 $283 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 $2,950 deductible. Benefits from High Deductible Plan F will not begin until out-of-pocket expenses are $2,950. 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 $2,950 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,950 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 $283 of Medicare-Approved amounts*	$0	$283 (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 $283 of Medicare-Approved amounts*	$0	$283 (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 $2,950 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,950 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $283 of Medicare-Approved amounts*	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,950 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,950 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 $1,736	$1,736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after While using 60 lifetime reserve days	All but $868 a day	$868 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 $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN G

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

*Once you have been billed $283 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 $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $283 of Medicare-Approved amounts*	$0	$0	$283 (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 $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after While using 60 lifetime reserve days	All but $868 a day	$868 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 $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN N

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

*Once you have been billed $283 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 $283 of Medicare-Approved amounts*	$0	$0	$283 (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 $283 of Medicare-Approved amounts*	$0	$0	$283 (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 $283 of Medicare-Approved amounts*	$0	$0	$283 (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