Outline of coverage

Medicare Supplement Insurance

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

Pennsylvania

Underwritten by

Aetna Health Insurance Company

AetnaSeniorProducts.com

AHCMS04874PA

Rates effective: 06/2023 B

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make available Plans A, B and D or G. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and High Deductible F.

Note: A ✓ means 100% of the benefit is paid.

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

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

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

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

Aetna Health Insurance Company
Annual premiums
For use in ZIP Codes: 150-154 and 156
Female rates

Rates effective 6/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,536	1,710	2,199	1,712	566	1,142
65	1,536	1,710	2,199	1,712	566	1,142
66	1,536	1,710	2,199	1,712	566	1,142
67	1,536	1,710	2,199	1,712	566	1,142
68	1,554	1,728	2,223	1,732	572	1,183
69	1,588	1,769	2,272	1,771	585	1,232
70	1,632	1,816	2,333	1,818	600	1,280
71	1,681	1,869	2,405	1,872	619	1,324
72	1,734	1,929	2,481	1,930	637	1,370
73	1,791	1,991	2,560	1,993	658	1,415
74	1,852	2,061	2,650	2,063	682	1,464
75	1,918	2,132	2,743	2,136	705	1,511
76	1,985	2,208	2,838	2,210	730	1,558
77	2,055	2,285	2,938	2,287	756	1,611
78	2,125	2,363	3,038	2,366	782	1,665
79	2,191	2,437	3,133	2,439	806	1,718
80	2,260	2,515	3,232	2,517	831	1,776
81	2,330	2,593	3,334	2,596	858	1,831
82	2,400	2,670	3,433	2,674	883	1,886
83	2,474	2,752	3,539	2,757	910	1,945
84	2,546	2,832	3,642	2,836	936	2,001
85	2,638	2,935	3,773	2,939	971	2,073
86	2,715	3,021	3,881	3,025	998	2,132
87	2,791	3,106	3,991	3,110	1,027	2,193
88	2,869	3,191	4,104	3,197	1,056	2,254
89	2,949	3,279	4,218	3,286	1,084	2,318
90	3,029	3,372	4,333	3,375	1,114	2,382
91	3,112	3,463	4,453	3,467	1,145	2,446
92	3,197	3,555	4,571	3,560	1,176	2,512
93	3,282	3,650	4,694	3,657	1,208	2,578
94	3,370	3,747	4,817	3,752	1,240	2,647
95	3,457	3,846	4,943	3,851	1,272	2,716
96	3,547	3,943	5,073	3,949	1,304	2,786
97	3,636	4,043	5,201	4,051	1,337	2,858
98	3,728	4,147	5,334	4,154	1,372	2,930
99+	3,821	4,252	5,466	4,257	1,405	3,003

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,708	1,900	2,443	1,904	629	1,268
65	1,708	1,900	2,443	1,904	629	1,268
66	1,708	1,900	2,443	1,904	629	1,268
67	1,708	1,900	2,443	1,904	629	1,268
68	1,726	1,922	2,469	1,924	635	1,314
69	1,765	1,965	2,527	1,968	651	1,369
70	1,815	2,017	2,592	2,019	667	1,423
71	1,866	2,077	2,671	2,080	688	1,471
72	1,925	2,142	2,754	2,145	708	1,521
73	1,990	2,211	2,845	2,215	731	1,572
74	2,060	2,289	2,944	2,292	758	1,626
75	2,131	2,370	3,048	2,372	783	1,678
76	2,206	2,453	3,154	2,456	812	1,732
77	2,283	2,539	3,265	2,543	840	1,791
78	2,361	2,625	3,375	2,629	869	1,850
79	2,435	2,707	3,480	2,712	896	1,910
80	2,510	2,793	3,590	2,796	923	1,973
81	2,590	2,881	3,704	2,884	953	2,034
82	2,668	2,966	3,816	2,970	981	2,095
83	2,749	3,058	3,931	3,062	1,011	2,161
84	2,829	3,148	4,047	3,151	1,040	2,223
85	2,933	3,261	4,193	3,266	1,079	2,305
86	3,015	3,355	4,314	3,359	1,109	2,369
87	3,100	3,450	4,436	3,453	1,141	2,438
88	3,187	3,545	4,561	3,552	1,173	2,505
89	3,275	3,644	4,687	3,649	1,205	2,575
90	3,366	3,746	4,814	3,751	1,239	2,645
91	3,459	3,847	4,947	3,854	1,273	2,717
92	3,552	3,949	5,080	3,957	1,308	2,790
93	3,646	4,056	5,216	4,063	1,342	2,866
94	3,743	4,164	5,353	4,170	1,378	2,941
95	3,840	4,273	5,494	4,279	1,413	3,018
96	3,941	4,383	5,635	4,388	1,449	3,097
97	4,039	4,493	5,778	4,501	1,486	3,174
98	4,142	4,607	5,925	4,615	1,525	3,256
99+	4,248	4,723	6,073	4,731	1,562	3,337

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: 150-154 and 156
Male rates

Rates effective 6/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,768	1,968	2,529	1,970	651	1,313
65	1,768	1,968	2,529	1,970	651	1,313
66	1,768	1,968	2,529	1,970	651	1,313
67	1,768	1,968	2,529	1,970	651	1,313
68	1,787	1,988	2,556	1,991	658	1,359
69	1,829	2,034	2,614	2,037	673	1,417
70	1,878	2,087	2,683	2,091	690	1,472
71	1,932	2,149	2,765	2,153	712	1,523
72	1,993	2,217	2,852	2,220	733	1,576
73	2,060	2,289	2,945	2,292	757	1,626
74	2,130	2,370	3,048	2,372	784	1,684
75	2,206	2,453	3,154	2,455	811	1,737
76	2,282	2,539	3,264	2,543	840	1,792
77	2,363	2,629	3,381	2,632	869	1,853
78	2,441	2,717	3,494	2,721	899	1,915
79	2,520	2,801	3,602	2,806	927	1,977
80	2,597	2,891	3,716	2,895	956	2,042
81	2,681	2,982	3,834	2,985	987	2,106
82	2,760	3,071	3,947	3,075	1,015	2,170
83	2,845	3,165	4,070	3,168	1,047	2,237
84	2,930	3,259	4,188	3,261	1,076	2,301
85	3,034	3,375	4,338	3,381	1,117	2,385
86	3,121	3,472	4,464	3,479	1,148	2,452
87	3,210	3,572	4,591	3,575	1,181	2,522
88	3,301	3,669	4,720	3,677	1,214	2,593
89	3,391	3,772	4,850	3,777	1,247	2,666
90	3,485	3,878	4,984	3,882	1,281	2,739
91	3,578	3,980	5,120	3,988	1,317	2,813
92	3,677	4,087	5,259	4,096	1,352	2,889
93	3,773	4,198	5,399	4,206	1,389	2,965
94	3,874	4,310	5,540	4,316	1,426	3,044
95	3,976	4,423	5,684	4,429	1,463	3,123
96	4,078	4,534	5,833	4,543	1,500	3,205
97	4,181	4,651	5,981	4,659	1,538	3,286
98	4,286	4,767	6,133	4,777	1,578	3,371
99+	4,394	4,890	6,287	4,896	1,616	3,455

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,962	2,185	2,811	2,190	723	1,459
65	1,962	2,185	2,811	2,190	723	1,459
66	1,962	2,185	2,811	2,190	723	1,459
67	1,962	2,185	2,811	2,190	723	1,459
68	1,985	2,210	2,839	2,211	730	1,512
69	2,031	2,260	2,905	2,262	749	1,574
70	2,085	2,320	2,981	2,323	767	1,635
71	2,147	2,389	3,072	2,392	791	1,693
72	2,215	2,463	3,168	2,466	814	1,750
73	2,287	2,543	3,273	2,546	841	1,807
74	2,367	2,634	3,384	2,636	872	1,871
75	2,452	2,726	3,505	2,728	900	1,930
76	2,537	2,821	3,627	2,826	934	1,992
77	2,627	2,919	3,755	2,923	966	2,060
78	2,715	3,021	3,881	3,025	999	2,128
79	2,800	3,114	4,003	3,118	1,030	2,197
80	2,888	3,213	4,130	3,217	1,061	2,270
81	2,979	3,312	4,258	3,318	1,096	2,339
82	3,068	3,413	4,387	3,418	1,128	2,410
83	3,161	3,516	4,521	3,522	1,163	2,485
84	3,255	3,620	4,654	3,623	1,196	2,558
85	3,372	3,750	4,823	3,756	1,241	2,651
86	3,467	3,857	4,961	3,864	1,275	2,724
87	3,567	3,969	5,099	3,973	1,312	2,804
88	3,665	4,078	5,245	4,085	1,349	2,880
89	3,769	4,191	5,390	4,196	1,386	2,961
90	3,871	4,307	5,537	4,314	1,425	3,043
91	3,977	4,424	5,687	4,431	1,464	3,126
92	4,085	4,544	5,841	4,551	1,504	3,209
93	4,193	4,667	5,998	4,672	1,543	3,295
94	4,303	4,787	6,155	4,796	1,585	3,382
95	4,415	4,913	6,318	4,921	1,625	3,470
96	4,532	5,039	6,480	5,046	1,666	3,560
97	4,645	5,169	6,646	5,176	1,709	3,650
98	4,763	5,297	6,814	5,308	1,754	3,743
99+	4,885	5,434	6,984	5,440	1,796	3,838

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: 189-194
Female rates

Rates effective 6/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,657	1,844	2,371	1,846	610	1,231
65	1,657	1,844	2,371	1,846	610	1,231
66	1,657	1,844	2,371	1,846	610	1,231
67	1,657	1,844	2,371	1,846	610	1,231
68	1,675	1,864	2,397	1,867	616	1,276
69	1,712	1,907	2,450	1,910	631	1,328
70	1,760	1,958	2,516	1,960	647	1,380
71	1,813	2,015	2,593	2,019	667	1,427
72	1,870	2,079	2,675	2,081	687	1,477
73	1,931	2,146	2,760	2,149	709	1,525
74	1,996	2,222	2,857	2,225	735	1,579
75	2,068	2,299	2,957	2,303	760	1,629
76	2,140	2,381	3,060	2,383	787	1,680
77	2,216	2,464	3,168	2,466	815	1,737
78	2,292	2,548	3,276	2,551	843	1,796
79	2,362	2,628	3,378	2,630	869	1,853
80	2,437	2,712	3,484	2,714	897	1,915
81	2,512	2,796	3,595	2,799	925	1,974
82	2,588	2,879	3,701	2,883	952	2,034
83	2,667	2,967	3,815	2,972	981	2,097
84	2,745	3,054	3,927	3,058	1,009	2,158
85	2,845	3,164	4,068	3,169	1,047	2,236
86	2,928	3,257	4,185	3,261	1,076	2,299
87	3,009	3,349	4,303	3,353	1,107	2,365
88	3,094	3,441	4,426	3,447	1,138	2,430
89	3,179	3,535	4,548	3,543	1,169	2,500
90	3,266	3,636	4,672	3,639	1,202	2,568
91	3,355	3,734	4,801	3,739	1,235	2,637
92	3,447	3,833	4,929	3,839	1,269	2,708
93	3,539	3,936	5,062	3,943	1,302	2,780
94	3,633	4,040	5,194	4,046	1,337	2,854
95	3,727	4,147	5,330	4,153	1,371	2,929
96	3,824	4,252	5,470	4,258	1,406	3,005
97	3,921	4,360	5,609	4,369	1,442	3,081
98	4,020	4,471	5,751	4,479	1,479	3,160
99+	4,121	4,584	5,894	4,590	1,515	3,238

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,841	2,048	2,634	2,053	678	1,368
65	1,841	2,048	2,634	2,053	678	1,368
66	1,841	2,048	2,634	2,053	678	1,368
67	1,841	2,048	2,634	2,053	678	1,368
68	1,861	2,072	2,662	2,075	684	1,417
69	1,903	2,119	2,724	2,122	702	1,476
70	1,957	2,175	2,795	2,177	719	1,534
71	2,013	2,239	2,881	2,243	742	1,586
72	2,076	2,310	2,970	2,313	764	1,641
73	2,145	2,385	3,068	2,388	789	1,695
74	2,221	2,468	3,174	2,471	817	1,753
75	2,298	2,556	3,286	2,558	844	1,809
76	2,378	2,645	3,401	2,649	875	1,867
77	2,461	2,738	3,520	2,742	905	1,931
78	2,546	2,831	3,639	2,835	937	1,995
79	2,625	2,919	3,752	2,924	966	2,060
80	2,707	3,012	3,871	3,014	996	2,128
81	2,792	3,106	3,994	3,110	1,028	2,194
82	2,877	3,198	4,114	3,203	1,058	2,259
83	2,964	3,297	4,238	3,302	1,090	2,330
84	3,050	3,394	4,364	3,398	1,121	2,397
85	3,162	3,517	4,521	3,522	1,163	2,485
86	3,251	3,617	4,651	3,622	1,195	2,554
87	3,343	3,720	4,783	3,724	1,230	2,629
88	3,436	3,823	4,918	3,830	1,265	2,701
89	3,532	3,930	5,054	3,935	1,300	2,776
90	3,629	4,039	5,191	4,045	1,335	2,852
91	3,730	4,148	5,334	4,155	1,373	2,930
92	3,830	4,258	5,477	4,267	1,410	3,008
93	3,931	4,373	5,625	4,381	1,447	3,090
94	4,036	4,490	5,772	4,496	1,486	3,171
95	4,140	4,608	5,923	4,614	1,524	3,254
96	4,249	4,726	6,076	4,732	1,562	3,339
97	4,355	4,845	6,230	4,853	1,602	3,422
98	4,466	4,967	6,388	4,976	1,644	3,510
99+	4,581	5,093	6,548	5,101	1,684	3,598

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: 189-194
Male rates

Rates effective 6/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,906	2,122	2,727	2,124	702	1,416
65	1,906	2,122	2,727	2,124	702	1,416
66	1,906	2,122	2,727	2,124	702	1,416
67	1,906	2,122	2,727	2,124	702	1,416
68	1,927	2,144	2,757	2,146	709	1,466
69	1,972	2,194	2,819	2,196	725	1,528
70	2,025	2,251	2,893	2,254	744	1,587
71	2,083	2,318	2,981	2,321	768	1,642
72	2,149	2,391	3,075	2,393	790	1,699
73	2,221	2,468	3,176	2,471	816	1,753
74	2,296	2,556	3,286	2,558	846	1,815
75	2,378	2,645	3,401	2,647	874	1,872
76	2,460	2,738	3,519	2,742	905	1,932
77	2,548	2,835	3,646	2,838	937	1,998
78	2,633	2,930	3,767	2,934	970	2,065
79	2,717	3,021	3,884	3,026	999	2,132
80	2,800	3,117	4,006	3,121	1,030	2,202
81	2,890	3,215	4,134	3,219	1,064	2,270
82	2,976	3,311	4,256	3,316	1,095	2,340
83	3,068	3,412	4,388	3,416	1,128	2,412
84	3,160	3,514	4,516	3,517	1,161	2,481
85	3,271	3,639	4,677	3,646	1,204	2,572
86	3,365	3,744	4,814	3,751	1,238	2,644
87	3,461	3,851	4,950	3,855	1,273	2,719
88	3,559	3,956	5,089	3,964	1,309	2,796
89	3,657	4,067	5,229	4,072	1,344	2,874
90	3,757	4,181	5,374	4,186	1,381	2,954
91	3,858	4,292	5,520	4,300	1,420	3,033
92	3,964	4,407	5,671	4,417	1,458	3,115
93	4,068	4,526	5,822	4,535	1,498	3,197
94	4,178	4,648	5,973	4,654	1,538	3,282
95	4,287	4,769	6,129	4,775	1,577	3,368
96	4,397	4,889	6,289	4,898	1,617	3,456
97	4,509	5,015	6,449	5,023	1,658	3,543
98	4,621	5,140	6,613	5,151	1,701	3,634
99+	4,738	5,272	6,779	5,279	1,742	3,725

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	2,115	2,356	3,031	2,361	780	1,574
65	2,115	2,356	3,031	2,361	780	1,574
66	2,115	2,356	3,031	2,361	780	1,574
67	2,115	2,356	3,031	2,361	780	1,574
68	2,140	2,383	3,062	2,385	787	1,631
69	2,190	2,437	3,132	2,439	807	1,698
70	2,248	2,501	3,214	2,505	827	1,763
71	2,315	2,575	3,312	2,579	853	1,825
72	2,388	2,656	3,416	2,659	878	1,887
73	2,466	2,742	3,529	2,745	906	1,948
74	2,552	2,840	3,649	2,842	940	2,017
75	2,644	2,939	3,780	2,941	971	2,081
76	2,735	3,042	3,911	3,047	1,007	2,148
77	2,832	3,147	4,049	3,152	1,042	2,221
78	2,928	3,257	4,185	3,261	1,078	2,294
79	3,019	3,358	4,316	3,362	1,111	2,368
80	3,114	3,465	4,453	3,468	1,145	2,448
81	3,212	3,571	4,592	3,577	1,182	2,522
82	3,308	3,680	4,731	3,685	1,216	2,599
83	3,409	3,791	4,874	3,798	1,254	2,680
84	3,509	3,904	5,018	3,906	1,290	2,758
85	3,636	4,044	5,201	4,050	1,338	2,858
86	3,739	4,159	5,349	4,166	1,375	2,938
87	3,846	4,279	5,498	4,284	1,415	3,023
88	3,952	4,397	5,656	4,404	1,455	3,105
89	4,063	4,519	5,812	4,525	1,494	3,193
90	4,174	4,644	5,971	4,651	1,536	3,281
91	4,288	4,770	6,132	4,778	1,579	3,370
92	4,404	4,899	6,298	4,907	1,622	3,460
93	4,521	5,032	6,468	5,038	1,664	3,553
94	4,640	5,162	6,636	5,171	1,709	3,647
95	4,760	5,297	6,813	5,306	1,752	3,741
96	4,887	5,434	6,987	5,441	1,797	3,839
97	5,008	5,574	7,166	5,581	1,843	3,936
98	5,136	5,711	7,347	5,724	1,891	4,036
99+	5,268	5,859	7,531	5,865	1,937	4,138

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

To calculate a Household discount:

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

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

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

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

Rates effective 6/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,336	1,487	1,912	1,489	492	993
65	1,336	1,487	1,912	1,489	492	993
66	1,336	1,487	1,912	1,489	492	993
67	1,336	1,487	1,912	1,489	492	993
68	1,351	1,503	1,933	1,506	497	1,029
69	1,381	1,538	1,976	1,540	509	1,071
70	1,419	1,579	2,029	1,581	522	1,113
71	1,462	1,625	2,091	1,628	538	1,151
72	1,508	1,677	2,157	1,678	554	1,191
73	1,557	1,731	2,226	1,733	572	1,230
74	1,610	1,792	2,304	1,794	593	1,273
75	1,668	1,854	2,385	1,857	613	1,314
76	1,726	1,920	2,468	1,922	635	1,355
77	1,787	1,987	2,555	1,989	657	1,401
78	1,848	2,055	2,642	2,057	680	1,448
79	1,905	2,119	2,724	2,121	701	1,494
80	1,965	2,187	2,810	2,189	723	1,544
81	2,026	2,255	2,899	2,257	746	1,592
82	2,087	2,322	2,985	2,325	768	1,640
83	2,151	2,393	3,077	2,397	791	1,691
84	2,214	2,463	3,167	2,466	814	1,740
85	2,294	2,552	3,281	2,556	844	1,803
86	2,361	2,627	3,375	2,630	868	1,854
87	2,427	2,701	3,470	2,704	893	1,907
88	2,495	2,775	3,569	2,780	918	1,960
89	2,564	2,851	3,668	2,857	943	2,016
90	2,634	2,932	3,768	2,935	969	2,071
91	2,706	3,011	3,872	3,015	996	2,127
92	2,780	3,091	3,975	3,096	1,023	2,184
93	2,854	3,174	4,082	3,180	1,050	2,242
94	2,930	3,258	4,189	3,263	1,078	2,302
95	3,006	3,344	4,298	3,349	1,106	2,362
96	3,084	3,429	4,411	3,434	1,134	2,423
97	3,162	3,516	4,523	3,523	1,163	2,485
98	3,242	3,606	4,638	3,612	1,193	2,548
99+	3,323	3,697	4,753	3,702	1,222	2,611

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,485	1,652	2,124	1,656	547	1,103
65	1,485	1,652	2,124	1,656	547	1,103
66	1,485	1,652	2,124	1,656	547	1,103
67	1,485	1,652	2,124	1,656	547	1,103
68	1,501	1,671	2,147	1,673	552	1,143
69	1,535	1,709	2,197	1,711	566	1,190
70	1,578	1,754	2,254	1,756	580	1,237
71	1,623	1,806	2,323	1,809	598	1,279
72	1,674	1,863	2,395	1,865	616	1,323
73	1,730	1,923	2,474	1,926	636	1,367
74	1,791	1,990	2,560	1,993	659	1,414
75	1,853	2,061	2,650	2,063	681	1,459
76	1,918	2,133	2,743	2,136	706	1,506
77	1,985	2,208	2,839	2,211	730	1,557
78	2,053	2,283	2,935	2,286	756	1,609
79	2,117	2,354	3,026	2,358	779	1,661
80	2,183	2,429	3,122	2,431	803	1,716
81	2,252	2,505	3,221	2,508	829	1,769
82	2,320	2,579	3,318	2,583	853	1,822
83	2,390	2,659	3,418	2,663	879	1,879
84	2,460	2,737	3,519	2,740	904	1,933
85	2,550	2,836	3,646	2,840	938	2,004
86	2,622	2,917	3,751	2,921	964	2,060
87	2,696	3,000	3,857	3,003	992	2,120
88	2,771	3,083	3,966	3,089	1,020	2,178
89	2,848	3,169	4,076	3,173	1,048	2,239
90	2,927	3,257	4,186	3,262	1,077	2,300
91	3,008	3,345	4,302	3,351	1,107	2,363
92	3,089	3,434	4,417	3,441	1,137	2,426
93	3,170	3,527	4,536	3,533	1,167	2,492
94	3,255	3,621	4,655	3,626	1,198	2,557
95	3,339	3,716	4,777	3,721	1,229	2,624
96	3,427	3,811	4,900	3,816	1,260	2,693
97	3,512	3,907	5,024	3,914	1,292	2,760
98	3,602	4,006	5,152	4,013	1,326	2,831
99+	3,694	4,107	5,281	4,114	1,358	2,902

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

To calculate a Household discount:

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

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

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

Aetna Health Insurance Company

Annual premiums

For use in: Rest of State

Male rates

Rates effective 6/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,537	1,711	2,199	1,713	566	1,142
65	1,537	1,711	2,199	1,713	566	1,142
66	1,537	1,711	2,199	1,713	566	1,142
67	1,537	1,711	2,199	1,713	566	1,142
68	1,554	1,729	2,223	1,731	572	1,182
69	1,590	1,769	2,273	1,771	585	1,232
70	1,633	1,815	2,333	1,818	600	1,280
71	1,680	1,869	2,404	1,872	619	1,324
72	1,733	1,928	2,480	1,930	637	1,370
73	1,791	1,990	2,561	1,993	658	1,414
74	1,852	2,061	2,650	2,063	682	1,464
75	1,918	2,133	2,743	2,135	705	1,510
76	1,984	2,208	2,838	2,211	730	1,558
77	2,055	2,286	2,940	2,289	756	1,611
78	2,123	2,363	3,038	2,366	782	1,665
79	2,191	2,436	3,132	2,440	806	1,719
80	2,258	2,514	3,231	2,517	831	1,776
81	2,331	2,593	3,334	2,596	858	1,831
82	2,400	2,670	3,432	2,674	883	1,887
83	2,474	2,752	3,539	2,755	910	1,945
84	2,548	2,834	3,642	2,836	936	2,001
85	2,638	2,935	3,772	2,940	971	2,074
86	2,714	3,019	3,882	3,025	998	2,132
87	2,791	3,106	3,992	3,109	1,027	2,193
88	2,870	3,190	4,104	3,197	1,056	2,255
89	2,949	3,280	4,217	3,284	1,084	2,318
90	3,030	3,372	4,334	3,376	1,114	2,382
91	3,111	3,461	4,452	3,468	1,145	2,446
92	3,197	3,554	4,573	3,562	1,176	2,512
93	3,281	3,650	4,695	3,657	1,208	2,578
94	3,369	3,748	4,817	3,753	1,240	2,647
95	3,457	3,846	4,943	3,851	1,272	2,716
96	3,546	3,943	5,072	3,950	1,304	2,787
97	3,636	4,044	5,201	4,051	1,337	2,857
98	3,727	4,145	5,333	4,154	1,372	2,931
99+	3,821	4,252	5,467	4,257	1,405	3,004

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,706	1,900	2,444	1,904	629	1,269
65	1,706	1,900	2,444	1,904	629	1,269
66	1,706	1,900	2,444	1,904	629	1,269
67	1,706	1,900	2,444	1,904	629	1,269
68	1,726	1,922	2,469	1,923	635	1,315
69	1,766	1,965	2,526	1,967	651	1,369
70	1,813	2,017	2,592	2,020	667	1,422
71	1,867	2,077	2,671	2,080	688	1,472
72	1,926	2,142	2,755	2,144	708	1,522
73	1,989	2,211	2,846	2,214	731	1,571
74	2,058	2,290	2,943	2,292	758	1,627
75	2,132	2,370	3,048	2,372	783	1,678
76	2,206	2,453	3,154	2,457	812	1,732
77	2,284	2,538	3,265	2,542	840	1,791
78	2,361	2,627	3,375	2,630	869	1,850
79	2,435	2,708	3,481	2,711	896	1,910
80	2,511	2,794	3,591	2,797	923	1,974
81	2,590	2,880	3,703	2,885	953	2,034
82	2,668	2,968	3,815	2,972	981	2,096
83	2,749	3,057	3,931	3,063	1,011	2,161
84	2,830	3,148	4,047	3,150	1,040	2,224
85	2,932	3,261	4,194	3,266	1,079	2,305
86	3,015	3,354	4,314	3,360	1,109	2,369
87	3,102	3,451	4,434	3,455	1,141	2,438
88	3,187	3,546	4,561	3,552	1,173	2,504
89	3,277	3,644	4,687	3,649	1,205	2,575
90	3,366	3,745	4,815	3,751	1,239	2,646
91	3,458	3,847	4,945	3,853	1,273	2,718
92	3,552	3,951	5,079	3,957	1,308	2,790
93	3,646	4,058	5,216	4,063	1,342	2,865
94	3,742	4,163	5,352	4,170	1,378	2,941
95	3,839	4,272	5,494	4,279	1,413	3,017
96	3,941	4,382	5,635	4,388	1,449	3,096
97	4,039	4,495	5,779	4,501	1,486	3,174
98	4,142	4,606	5,925	4,616	1,525	3,255
99+	4,248	4,725	6,073	4,730	1,562	3,337

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

To calculate a Household discount:

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

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

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

PREMIUM INFORMATION

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

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 have a Medicare supplement policy with an Aetna company. The Medicare eligible adult must be either (a) your spouse or someone with whom you are in a civil union partnership; and (b) someone with whom you have continuously resided for the past 12 months. The household discount will only be applicable if a policy for each applicant is issued. The discounted rates 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 costs.

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.

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.

THE FOLLOWING CHARTS DESCRIBE PLANS A, B, F, G, HIGH DEDUCTIBLE G and N OFFERED BY AETNA HEALTH INSURANCE COMPANY.

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$0	$1,632 (Part A Deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE 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.

****This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,800 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

HIGH DEDUCTIBLE PLAN G

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

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

****This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,800 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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

HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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