Outline of Coverage

Medicare Supplement Insurance Plan

Aetna Health Insurance Company

Benefit plans: Basic plan

Wisconsin

aetna®

AHCMS04876WI

Rates effective: 03/2024 A

AETNA HEALTH INSURANCE COMPANY
1021 Reams Fleming Blvd., Franklin, Tennessee, 37064
Telephone: 800-264-4000

OUTLINE OF MEDICARE SUPPLEMENT INSURANCE
OUTLINE OF COVERAGE FOR POLICY FORM AHIMSP19BC WI

MEDICARE SUPPLEMENT INSURANCE

The Wisconsin Insurance Commissioner has set standards for Medicare Supplement Insurance. This policy meets these standards. It, along with Medicare, may not cover all your medical costs. You should review carefully all policy limitations. For an explanation of these standards and other important information, see *Wisconsin Guide to Health Insurance for People with Medicare*, given to you when you applied for the policy. Do not buy the policy if you did not get this guide.

PREMIUM INFORMATION -We, Aetna Health Insurance Company can only raise your premium if we raise the premium for all policies like yours in the same geographic area in this state. Your premium will change each year. The new premium will be based on your age.

DISCLOSURES - Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY -This is only an Outline of Coverage describing your policy's most important features. This is not 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 you are not satisfied with your policy, you may return it to Aetna Health Insurance Company, P.O. Box 14770, Lexington, KY 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 of your payments directly to you.

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 fully 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 AND YOU" FOR MORE DETAILS.

AETNA HEALTH INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT INSURANCE

BASIC PLAN
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.
*NOTICE: When your Medicare Part A hospital benefits are exhausted, the issuer stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits."
**These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

MEDICARE PART A BENEFITS	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies (Does not include personal items)			
First 60 days	All but $1,632	$0 or	$1,632 (Part A Deductible) or
		☐ Part A Deductible Rider**	$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

MEDICARE PART A BENEFITS	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
INPATIENT PSYCHIATRIC CARE Inpatient psychiatric care in a participating psychiatric hospital	190 days per lifetime	175 days per lifetime	All charges not covered by policy nor by Medicare
BLOOD			
First 3 pints	$0	First 3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

BASIC PLAN

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services your Part B deductible will have been met for the calendar year.
**These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

MEDICARE PART B BENEFITS	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
MEDICAL EXPENSES Eligible expense for physician's services, in-patient and out-patient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts	$0	$0 or	$240 or
		☐ Optional Part B Deductible Rider***	$0
Remainder of Medicare-Approved amounts	Generally 80%	☐ Optional Medicare Copayment or Coinsurance Rider**	Up to $20 per office visit and up to $50 per emergency room visit.
		Generally 20%	Charges in excess of 20% up to the limiting charge
		☐ Optional Medicare Part B Excess Charges Rider**	Balance, if any, or expenses if not covered by Medicare or this policy
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0 or	$240 or
		☐ Optional Part B Deductible Rider***	$0
Remainder of Medicare-Approved amounts	80%	20%	Charges not covered by the policy or Medicare

MEDICARE PART B BENEFITS	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
CLINICAL LABORATORY SERVICES Tests for diagnostic services	100%	$0	$0
HOME HEALTH CARE	100% of charges for visits considered medically necessary by Medicare	40 visits or ☐ Optional Additional Home Health Care Rider**	Charges not covered by policy or Medicare

**These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

BASIC PLAN

OTHER BENEFITS – NOT COVERED BY MEDICARE

<table>
<tr><th></th><th>MEDICARE PAYS</th><th>PLAN PAYS</th><th>YOU PAY</th></tr>
<tr><td>PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE
Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare</td><td colspan="3"></td></tr>
<tr><td>First $120 each calendar year</td><td>$0</td><td>$120</td><td rowspan="2">Charges not covered by policy or Medicare</td></tr>
<tr><td>Additional charges</td><td>$0</td><td>$0</td></tr>
<tr><td>FOREIGN TRAVEL – NOT COVERED BY MEDICARE
Medically necessary emergency care services beginning during the first 60 days of each trip outside of the USA</td><td colspan="3"></td></tr>
<tr><td>First $250 each calendar year</td><td>$0</td><td>$0</td><td>$250</td></tr>
<tr><td rowspan="2">Remainder of charges</td><td rowspan="2">$0</td><td>$0 or</td><td>All costs or</td></tr>
<tr><td>☐ Optional Foreign Travel Emergency Rider** (80% to a lifetime maximum benefit of $50,000)</td><td>20% and amounts over the $50,000 lifetime maximum</td></tr>
</table>

**These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

THE FOLLOWING BENEFITS ARE MANDATED BY YOUR STATE:

SKILLED NURSING FACILITY BENEFITS FOR NON-MEDICARE ELIGIBLE CONFINEMENT -We will pay the expenses you incur during any Medicare benefit period for confinement in a Wisconsin state licensed Skilled Nursing Facility, up to a maximum of 30 days. The daily rate payable shall be no less than the maximum daily rate established for skilled nursing care in that facility by the Department of Health and Social Services. Your confinement must be certified initially as Medically Necessary by the attending Physician and recertified every 7 days.

Benefits are not payable for services provided by or paid for by the Veterans Administration or Custodial Care or Skilled Nursing Facility confinement certified by Medicare.

KIDNEY DISEASE BENEFITS -We will pay the expenses you incur for treatment of kidney Disease by dialysis, transplantation and/or donor related services as defined by the Wisconsin Department of Health and Social Services, up to a maximum of $30,000 each calendar year. We will not pay for charges covered by another policy covering kidney disease expenses or for charges covered by Medicare.

DIABETES BENEFITS -We will pay the usual and customary charges for expenses incurred, and not covered by Medicare, for the installation and use of an insulin infusion pump or other equipment or supplies, including insulin or any other prescription medication, used in the treatment of diabetes and coverage of diabetic self-management education programs. Coverage for an insulin infusion pump is limited to one pump per year and is subject to a 30 day trial period prior to purchase.

Benefits are not payable if the equipment and supplies are covered under the Medicare Part D Prescription Drug program, whether or not the insured person is enrolled in a Medicare Part D plan.

CHIROPRACTIC BENEFITS -When Medicare Part B does not pay for Medically Necessary Services received from a Chiropractor, we will 100% of the usual and customary charges for chiropractor services. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other part of this policy.

HOSPITAL AND AMBULATORY SURGICAL CENTER CHARGES -We will pay the usual and customary charges incurred, and anesthetics provided, in conjunction with dental care that is provided to a covered individual in a Hospital or Ambulatory Surgical Center, if any of the Following applies:

a. you have a chronic disability that is attributable to a mental or physical impairment which results in a substantial functional limitation in an area of your major life activity, and the disability is likely to continue indefinitely.

b. you have a medical condition that requires hospitalization or general anesthesia for dental care.

BREAST RECONSTRUCTION BENEFITS -We will pay the usual and customary charges Incurred, not payable under Medicare, in the manner recommended by the attending Physician or Oncologist for breast reconstruction of the affected tissue incident to a mastectomy.

COLORECTAL EXAMS – We will pay your expense incurred for colorectal screening exams and lab tests if you are over 50 years of age or if you are under 50 years of age and are symptomatic or in a high-risk category. This coverage is subject to any deductible, coinsurance, co-payment, or other limitation on coverage applicable to other coverages under this policy. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other part of this policy.

CANCER CLINICAL TRIAL -We will provide coverage for the cost of any routine patient care that is administered to an insured in a cancer clinical trial satisfying the following criteria and would be covered under the policy, plan, or contract if the insured were not enrolled in the cancer clinical trial:

a. The purpose of the trial is to test whether the intervention potentially improves the trial participants' health outcomes.
b. The treatment provided as part of the trial is given with the intention of improving the trial participants' health outcomes.
c. The trial has therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
d. The trial does one of the following:
    1. Tests how to administer a health care service, item, or drug for the treatment of cancer.
    2. Tests responses to a health care service, item, or drug for the treatment of cancer.
    3. Compares the effectiveness of health care services, items, or drugs for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer.
    4. Studies new uses of health care services, items, or drugs for the treatment of cancer.
e. The trial is approved by one of the following:
    1. A National Institute of Health, or one of its cooperative groups or centers, under the federal department of health and human services.
    2. The Federal Food and Drug Administration.
    3. The Federal Department of Defense.
    4. The Federal Department of Veterans Affairs.

EXCEPTIONS, REDUCTIONS AND LIMITATIONS OF THE POLICY -We will not pay benefits for:

(1) expenses deemed unnecessary or unreasonable by Medicare, except in the Benefit Provisions and in Optional Riders, if any;
(2) expenses incurred prior to the coverage effective date;
(3) drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay);
(4) custodial care, dental care (except as provided in the mandated benefits) eye or ear examinations to prescribe or fit eyeglasses or hearing aids, routine immunizations, cosmetic surgery or routine foot care;
(5) services for which a charge is normally not made when there is no insurance;
(6) nursing home care costs (beyond what is covered by Medicare and the Wisconsin 30-day skilled nursing mandated by Wisconsin 632.895(3);
(7) home health care above the number of visits covered by Medicare and the 40-visits mandated by Wisconsin 632.895(2), unless you select the Additional Home Health Care Rider;
(8) care received outside the U.S.A.

Benefits will be increased to match any increases in Medicare deductible amounts or co-payment charges. The premium may automatically increase to correspond with these increases.

Renewability of the Policy -We will renew the policy each time you send us the premium. It must be paid on or before the date it is due or during the 31 days that follow.

Your premium will change on the first renewal date that coincides with or follows the anniversary date of the policy.

Material Misrepresentation -in the event of a material misrepresentation, the coverage will be cancelled as of the coverage effective date. A “material misrepresentation” occurs when a condition or combination of conditions you were requested to name on the application was not named and which, if named, would have caused us to deny issuing the coverage. This limitation for material misrepresentation is subject to the Time Limit for Certain defenses provision.

Review and Appeal - In the event of the denial of a claim under the Policy, You may appeal such denial by submitting a written request, which may be in any form and which may include supporting material, for our review. We will provide a description of the review and notification to you regarding the results of the review within 30 days after receiving your request.

Grievance -A grievance may be made by you or on your behalf in writing to us. A grievance is any dissatisfaction regarding our services, decision to rescind a policy, or claims practices.

IN ADDITION TO THIS OUTLINE OF COVERAGE, AETNA HEALTH INSURANCE COMPANY WILL SEND AN ANNUAL NOTICE TO YOU, 30 DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE CHANGES, WHICH WILL DESCRIBE THESE CHANGES AND THE CHANGES IN YOUR MEDICARE SUPPLEMENT COVERAGE.

MEDICARE SUPPLEMENT PREMIUM INFORMATION

ANNUAL PREMIUM

$_____ BASIC MEDICARE SUPPLEMENT COVERAGE

OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT POLICY - Each of these riders may be purchased separately.

$_____ MEDICARE PART A DEDUCTIBLE RIDER -100% of Part A Deductible

$_____ MEDICARE PART B DEDUCTIBLE RIDER -100% of Part B Deductible This rider is not available for those newly eligible for Medicare after January 1, 2020.

$_____ MEDICARE PART B EXCESS CHARGES RIDER - Difference between what Medicare pays and the amount charged by the provider which shall be no greater than the actual charge or the limiting charge allowed by Medicare, whichever is less.

$_____ ADDITIONAL HOME HEALTH CARE RIDER - An aggregate of 365 visits per year including those covered by Medicare.

$_____ FOREIGN TRAVEL EMERGENCY RIDER - After a deductible of not greater than $250, covers at least 80% of expenses associated with emergency medical care received outside the United States during the first 60 days of a trip with a maximum of at least $50,000.

$_____ MEDICARE PART B COPAYMENT OR COINSURANCE RIDER - Pays the Part B coinsurance subject to a copayment or coinsurance of no more than $20 per office visit and no more than $50 per emergency room visit or the Medicare Part B coinsurance that is in addition to the Medicare Part B medical deductible and in addition to out-of-pocket maximums.

$_____ TOTAL FOR BASIC POLICY, POLICY FEE AND SELECTED OPTIONAL RIDERS

Total Premium, if other than Annual Mode (at time of application), including premium for any Optional Rider selected above:

$_____ EFT $_____ Quarterly $_____ Semi-annual

Aetna Health Insurance Company

Annual Premiums
For Use in ZIP Codes: 531-534
Female Rates

Rates effective 3/1/2024

ATTAINED AGE	PREFERRED			STANDARD		
	Basic Policy	Basic Policy with Part B Copayment Rider	Part A Deductible Rider	Basic Policy	Basic Policy with Part B Copayment Rider	Part A Deductible Rider
Under 65	5,474	3,138	742	6,082	3,486	824
65	1,902	1,027	244	2,113	1,142	272
66	1,902	1,027	244	2,113	1,142	272
67	1,902	1,027	244	2,113	1,142	272
68	1,902	1,087	244	2,113	1,208	272
69	1,902	1,148	244	2,113	1,275	272
70	1,902	1,203	244	2,113	1,336	272
71	1,914	1,220	290	2,126	1,356	321
72	1,965	1,267	301	2,182	1,408	333
73	2,019	1,314	311	2,244	1,459	345
74	2,078	1,358	323	2,309	1,509	358
75	2,141	1,400	331	2,379	1,554	370
76	2,206	1,441	342	2,451	1,601	380
77	2,273	1,486	351	2,525	1,650	390
78	2,346	1,532	362	2,606	1,702	401
79	2,418	1,579	375	2,687	1,754	415
80	2,496	1,628	385	2,772	1,810	428
81	2,569	1,676	398	2,854	1,863	442
82	2,647	1,728	409	2,941	1,920	453
83	2,729	1,782	423	3,033	1,979	469
84	2,814	1,836	436	3,127	2,041	484
85	2,911	1,899	451	3,235	2,109	502
86	3,000	1,956	464	3,332	2,173	516
87	3,090	2,015	478	3,433	2,239	531
88	3,183	2,075	493	3,536	2,305	547
89	3,278	2,137	508	3,642	2,374	564
90	3,377	2,201	522	3,753	2,446	580
91	3,480	2,268	537	3,867	2,521	598
92	3,584	2,336	554	3,981	2,595	616
93	3,692	2,407	570	4,102	2,675	634
94	3,802	2,479	588	4,224	2,755	654
95	3,919	2,554	605	4,354	2,838	672
96	4,035	2,629	624	4,484	2,921	693
97	4,157	2,710	641	4,619	3,012	714
98	4,282	2,791	662	4,759	3,101	735
99+	4,411	2,875	682	4,901	3,194	757

ATTAINED AGE	PREFERRED				STANDARD			
	Additional Home Health Care Rider	Part B Deductible Rider	Foreign Travel Rider	Part B Excess Rider	Additional Home Health Care Rider	Part B Deductible Rider	Foreign Travel Rider	Part B Excess Rider
All	8	240	5	10	10	240	5	11

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: 531-534
Male Rates

Rates effective 3/1/2024

ATTAINED AGE	PREFERRED			STANDARD		
	Basic Policy	Basic Policy with Part B Copayment Rider	Part A Deductible Rider	Basic Policy	Basic Policy with Part B Copayment Rider	Part A Deductible Rider
Under 65	6,295	3,608	853	6,994	4,009	947
65	2,188	1,181	281	2,431	1,313	312
66	2,188	1,181	281	2,431	1,313	312
67	2,188	1,181	281	2,431	1,313	312
68	2,188	1,251	281	2,431	1,389	312
69	2,188	1,321	281	2,431	1,468	312
70	2,188	1,384	281	2,431	1,537	312
71	2,200	1,405	333	2,446	1,560	370
72	2,259	1,458	345	2,510	1,619	382
73	2,322	1,511	358	2,579	1,679	398
74	2,389	1,562	371	2,654	1,735	411
75	2,463	1,609	381	2,736	1,787	424
76	2,536	1,659	392	2,818	1,842	438
77	2,614	1,708	404	2,903	1,897	448
78	2,697	1,763	417	2,997	1,957	462
79	2,780	1,816	431	3,090	2,018	478
80	2,869	1,872	443	3,188	2,080	493
81	2,954	1,927	458	3,282	2,142	508
82	3,045	1,988	470	3,382	2,209	522
83	3,139	2,050	485	3,487	2,276	538
84	3,237	2,112	502	3,597	2,347	556
85	3,346	2,183	518	3,720	2,427	578
86	3,449	2,249	533	3,834	2,499	593
87	3,553	2,316	549	3,947	2,574	611
88	3,659	2,386	566	4,067	2,652	630
89	3,771	2,457	584	4,188	2,731	649
90	3,882	2,532	601	4,315	2,812	667
91	4,002	2,609	618	4,446	2,899	687
92	4,121	2,686	638	4,578	2,985	707
93	4,247	2,767	655	4,718	3,076	728
94	4,373	2,850	676	4,858	3,167	753
95	4,507	2,936	696	5,006	3,263	773
96	4,641	3,024	718	5,156	3,360	799
97	4,782	3,117	738	5,312	3,463	820
98	4,924	3,209	759	5,471	3,566	845
99+	5,072	3,306	785	5,636	3,673	871

ATTAINED AGE	PREFERRED				STANDARD			
	Additional Home Health Care Rider	Part B Deductible Rider	Foreign Travel Rider	Part B Excess Rider	Additional Home Health Care Rider	Part B Deductible Rider	Foreign Travel Rider	Part B Excess Rider
All	8	240	5	10	10	240	5	11

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 3/1/2024

ATTAINED AGE	PREFERRED			STANDARD		
	Basic Policy	Basic Policy with Part B Copayment Rider	Part A Deductible Rider	Basic Policy	Basic Policy with Part B Copayment Rider	Part A Deductible Rider
Under 65	4,310	2,471	584	4,789	2,745	649
65	1,498	809	192	1,664	899	214
66	1,498	809	192	1,664	899	214
67	1,498	809	192	1,664	899	214
68	1,498	856	192	1,664	951	214
69	1,498	904	192	1,664	1,004	214
70	1,498	947	192	1,664	1,052	214
71	1,507	961	228	1,674	1,068	253
72	1,547	998	237	1,718	1,109	262
73	1,590	1,035	245	1,767	1,149	272
74	1,636	1,069	254	1,818	1,188	282
75	1,686	1,102	261	1,873	1,224	291
76	1,737	1,135	269	1,930	1,261	299
77	1,790	1,170	276	1,988	1,299	307
78	1,847	1,206	285	2,052	1,340	316
79	1,904	1,243	295	2,116	1,381	327
80	1,965	1,282	303	2,183	1,425	337
81	2,023	1,320	313	2,247	1,467	348
82	2,084	1,361	322	2,316	1,512	357
83	2,149	1,403	333	2,388	1,558	369
84	2,216	1,446	343	2,462	1,607	381
85	2,292	1,495	355	2,547	1,661	395
86	2,362	1,540	365	2,624	1,711	406
87	2,433	1,587	376	2,703	1,763	418
88	2,506	1,634	388	2,784	1,815	431
89	2,581	1,683	400	2,868	1,869	444
90	2,659	1,733	411	2,955	1,926	457
91	2,740	1,786	423	3,045	1,985	471
92	2,822	1,839	436	3,135	2,043	485
93	2,907	1,895	449	3,230	2,106	499
94	2,994	1,952	463	3,326	2,169	515
95	3,086	2,011	476	3,428	2,235	529
96	3,177	2,070	491	3,531	2,300	546
97	3,273	2,134	505	3,637	2,372	562
98	3,372	2,198	521	3,747	2,442	579
99+	3,473	2,264	537	3,859	2,515	596

ATTAINED AGE	PREFERRED				STANDARD			
	Additional Home Health Care Rider	Part B Deductible Rider	Foreign Travel Rider	Part B Excess Rider	Additional Home Health Care Rider	Part B Deductible Rider	Foreign Travel Rider	Part B Excess Rider
All	6	240	4	8	8	240	4	9

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 3/1/2024

ATTAINED AGE	PREFERRED			STANDARD		
	Basic Policy	Basic Policy with Part B Copayment Rider	Part A Deductible Rider	Basic Policy	Basic Policy with Part B Copayment Rider	Part A Deductible Rider
Under 65	4,957	2,841	672	5,507	3,157	746
65	1,723	930	221	1,914	1,034	246
66	1,723	930	221	1,914	1,034	246
67	1,723	930	221	1,914	1,034	246
68	1,723	985	221	1,914	1,094	246
69	1,723	1,040	221	1,914	1,156	246
70	1,723	1,090	221	1,914	1,210	246
71	1,732	1,106	262	1,926	1,228	291
72	1,779	1,148	272	1,976	1,275	301
73	1,828	1,190	282	2,031	1,322	313
74	1,881	1,230	292	2,090	1,366	324
75	1,939	1,267	300	2,154	1,407	334
76	1,997	1,306	309	2,219	1,450	345
77	2,058	1,345	318	2,286	1,494	353
78	2,124	1,388	328	2,360	1,541	364
79	2,189	1,430	339	2,433	1,589	376
80	2,259	1,474	349	2,510	1,638	388
81	2,326	1,517	361	2,584	1,687	400
82	2,398	1,565	370	2,663	1,739	411
83	2,472	1,614	382	2,746	1,792	424
84	2,549	1,663	395	2,832	1,848	438
85	2,635	1,719	408	2,929	1,911	455
86	2,716	1,771	420	3,019	1,968	467
87	2,798	1,824	432	3,108	2,027	481
88	2,881	1,879	446	3,202	2,088	496
89	2,969	1,935	460	3,298	2,150	511
90	3,057	1,994	473	3,398	2,214	525
91	3,151	2,054	487	3,501	2,283	541
92	3,245	2,115	502	3,605	2,350	557
93	3,344	2,179	516	3,715	2,422	573
94	3,443	2,244	532	3,825	2,494	593
95	3,549	2,312	548	3,942	2,569	609
96	3,654	2,381	565	4,060	2,646	629
97	3,765	2,454	581	4,183	2,727	646
98	3,877	2,527	598	4,308	2,808	665
99+	3,994	2,603	618	4,438	2,892	686

ATTAINED AGE	PREFERRED				STANDARD			
	Additional Home Health Care Rider	Part B Deductible Rider	Foreign Travel Rider	Part B Excess Rider	Additional Home Health Care Rider	Part B Deductible Rider	Foreign Travel Rider	Part B Excess Rider
All	6	240	4	8	8	240	4	9

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