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

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Rates effective: 06/2024

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 6/1/2024

ATTAINED AGE	PREFERRED						ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N		Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,674	1,864	2,397	1,866	566	1,244	Under 65	1,862	2,071	2,662	2,076	629	1,382
65	1,674	1,864	2,397	1,866	566	1,244	65	1,862	2,071	2,662	2,076	629	1,382
66	1,674	1,864	2,397	1,866	566	1,244	66	1,862	2,071	2,662	2,076	629	1,382
67	1,674	1,864	2,397	1,866	566	1,244	67	1,862	2,071	2,662	2,076	629	1,382
68	1,694	1,884	2,423	1,888	572	1,290	68	1,881	2,094	2,691	2,098	635	1,433
69	1,731	1,927	2,477	1,931	585	1,342	69	1,924	2,142	2,754	2,145	651	1,492
70	1,779	1,979	2,544	1,981	600	1,395	70	1,978	2,199	2,826	2,201	667	1,550
71	1,833	2,037	2,621	2,041	619	1,443	71	2,034	2,264	2,912	2,268	688	1,603
72	1,891	2,102	2,704	2,103	637	1,493	72	2,099	2,336	3,003	2,338	708	1,658
73	1,952	2,170	2,790	2,172	658	1,542	73	2,169	2,410	3,102	2,414	731	1,714
74	2,018	2,246	2,888	2,248	682	1,596	74	2,245	2,494	3,209	2,498	758	1,772
75	2,091	2,324	2,990	2,328	705	1,647	75	2,323	2,583	3,322	2,586	783	1,829
76	2,163	2,407	3,094	2,409	730	1,699	76	2,405	2,674	3,439	2,677	812	1,888
77	2,240	2,491	3,203	2,493	756	1,756	77	2,489	2,768	3,559	2,772	840	1,952
78	2,316	2,576	3,312	2,578	782	1,815	78	2,574	2,861	3,679	2,866	869	2,017
79	2,387	2,657	3,414	2,659	806	1,872	79	2,654	2,951	3,793	2,956	896	2,082
80	2,463	2,742	3,522	2,744	831	1,935	80	2,736	3,045	3,913	3,048	923	2,151
81	2,539	2,827	3,634	2,829	858	1,995	81	2,823	3,140	4,038	3,144	953	2,217
82	2,616	2,911	3,742	2,914	883	2,056	82	2,908	3,233	4,160	3,237	981	2,284
83	2,697	2,999	3,857	3,005	910	2,119	83	2,996	3,333	4,285	3,338	1,011	2,355
84	2,775	3,088	3,970	3,091	936	2,182	84	3,083	3,430	4,411	3,435	1,040	2,423
85	2,875	3,199	4,112	3,204	971	2,260	85	3,197	3,555	4,570	3,560	1,079	2,512
86	2,959	3,292	4,231	3,297	998	2,324	86	3,287	3,657	4,702	3,662	1,109	2,582
87	3,042	3,386	4,349	3,389	1,027	2,391	87	3,380	3,761	4,835	3,764	1,141	2,658
88	3,128	3,479	4,474	3,485	1,056	2,456	88	3,473	3,864	4,971	3,872	1,173	2,730
89	3,214	3,574	4,598	3,581	1,084	2,527	89	3,570	3,972	5,109	3,978	1,205	2,807
90	3,302	3,675	4,723	3,679	1,114	2,596	90	3,669	4,083	5,247	4,089	1,239	2,883
91	3,393	3,774	4,853	3,779	1,145	2,666	91	3,771	4,193	5,392	4,201	1,273	2,962
92	3,485	3,874	4,983	3,881	1,176	2,738	92	3,872	4,304	5,537	4,314	1,308	3,041
93	3,578	3,979	5,116	3,986	1,208	2,811	93	3,973	4,421	5,686	4,429	1,342	3,123
94	3,673	4,084	5,251	4,091	1,240	2,885	94	4,080	4,539	5,835	4,545	1,378	3,205
95	3,769	4,192	5,388	4,198	1,272	2,961	95	4,186	4,658	5,988	4,664	1,413	3,289
96	3,866	4,299	5,529	4,304	1,304	3,037	96	4,295	4,777	6,142	4,783	1,449	3,375
97	3,964	4,407	5,670	4,416	1,337	3,115	97	4,402	4,898	6,297	4,906	1,486	3,459
98	4,064	4,521	5,813	4,528	1,372	3,194	98	4,515	5,022	6,458	5,030	1,525	3,549
99+	4,165	4,635	5,958	4,640	1,405	3,273	99+	4,630	5,149	6,619	5,157	1,562	3,637

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 6/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,926	2,145	2,757	2,147	651	1,432
65	1,926	2,145	2,757	2,147	651	1,432
66	1,926	2,145	2,757	2,147	651	1,432
67	1,926	2,145	2,757	2,147	651	1,432
68	1,948	2,168	2,786	2,170	658	1,481
69	1,993	2,217	2,850	2,220	673	1,544
70	2,047	2,275	2,924	2,279	690	1,604
71	2,106	2,343	3,013	2,346	712	1,659
72	2,172	2,417	3,108	2,420	733	1,717
73	2,245	2,494	3,210	2,498	757	1,772
74	2,322	2,583	3,322	2,586	784	1,835
75	2,405	2,674	3,439	2,676	811	1,893
76	2,487	2,768	3,557	2,772	840	1,953
77	2,576	2,866	3,686	2,869	869	2,019
78	2,661	2,962	3,808	2,966	899	2,087
79	2,746	3,053	3,926	3,059	927	2,155
80	2,830	3,151	4,050	3,156	956	2,226
81	2,922	3,250	4,179	3,255	987	2,295
82	3,008	3,347	4,302	3,352	1,015	2,366
83	3,102	3,450	4,437	3,453	1,047	2,438
84	3,194	3,552	4,566	3,555	1,076	2,508
85	3,306	3,679	4,728	3,686	1,117	2,600
86	3,402	3,785	4,866	3,792	1,148	2,673
87	3,498	3,894	5,004	3,897	1,181	2,749
88	3,597	3,999	5,144	4,008	1,214	2,827
89	3,696	4,111	5,287	4,117	1,247	2,906
90	3,798	4,226	5,433	4,232	1,281	2,985
91	3,900	4,338	5,581	4,347	1,317	3,066
92	4,008	4,455	5,733	4,465	1,352	3,149
93	4,112	4,576	5,886	4,584	1,389	3,232
94	4,223	4,698	6,039	4,705	1,426	3,318
95	4,333	4,821	6,196	4,828	1,463	3,404
96	4,445	4,943	6,357	4,952	1,500	3,494
97	4,557	5,069	6,519	5,078	1,538	3,581
98	4,671	5,196	6,685	5,207	1,578	3,674
99+	4,790	5,330	6,853	5,336	1,616	3,765

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	2,139	2,382	3,064	2,386	723	1,590
65	2,139	2,382	3,064	2,386	723	1,590
66	2,139	2,382	3,064	2,386	723	1,590
67	2,139	2,382	3,064	2,386	723	1,590
68	2,163	2,409	3,095	2,410	730	1,648
69	2,214	2,463	3,166	2,466	749	1,716
70	2,272	2,529	3,249	2,532	767	1,783
71	2,340	2,604	3,348	2,607	791	1,845
72	2,414	2,685	3,453	2,688	814	1,908
73	2,493	2,772	3,567	2,775	841	1,969
74	2,579	2,870	3,689	2,873	872	2,039
75	2,673	2,970	3,820	2,973	900	2,103
76	2,766	3,075	3,954	3,080	934	2,171
77	2,864	3,181	4,093	3,187	966	2,245
78	2,959	3,292	4,231	3,297	999	2,320
79	3,052	3,395	4,363	3,398	1,030	2,394
80	3,148	3,502	4,501	3,506	1,061	2,475
81	3,246	3,610	4,641	3,617	1,096	2,550
82	3,344	3,720	4,782	3,725	1,128	2,628
83	3,445	3,832	4,928	3,840	1,163	2,708
84	3,548	3,946	5,073	3,949	1,196	2,788
85	3,675	4,087	5,257	4,094	1,241	2,889
86	3,779	4,204	5,407	4,211	1,275	2,969
87	3,888	4,326	5,558	4,331	1,312	3,056
88	3,995	4,445	5,717	4,453	1,349	3,138
89	4,108	4,568	5,875	4,574	1,386	3,228
90	4,219	4,694	6,035	4,702	1,425	3,317
91	4,334	4,822	6,199	4,830	1,464	3,407
92	4,453	4,953	6,366	4,960	1,504	3,497
93	4,570	5,086	6,538	5,093	1,543	3,591
94	4,691	5,219	6,709	5,227	1,585	3,687
95	4,813	5,354	6,886	5,364	1,625	3,782
96	4,940	5,492	7,063	5,500	1,666	3,881
97	5,063	5,635	7,244	5,642	1,709	3,979
98	5,192	5,774	7,427	5,786	1,754	4,080
99+	5,325	5,923	7,613	5,929	1,796	4,183

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 6/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,805	2,010	2,584	2,013	610	1,342
65	1,805	2,010	2,584	2,013	610	1,342
66	1,805	2,010	2,584	2,013	610	1,342
67	1,805	2,010	2,584	2,013	610	1,342
68	1,827	2,031	2,613	2,036	616	1,391
69	1,866	2,078	2,671	2,082	631	1,447
70	1,918	2,134	2,743	2,137	647	1,504
71	1,977	2,196	2,826	2,201	667	1,556
72	2,039	2,267	2,915	2,268	687	1,610
73	2,104	2,340	3,008	2,342	709	1,663
74	2,176	2,422	3,114	2,424	735	1,721
75	2,254	2,506	3,224	2,510	760	1,776
76	2,332	2,595	3,336	2,598	787	1,831
77	2,416	2,686	3,453	2,688	815	1,893
78	2,497	2,778	3,571	2,780	843	1,957
79	2,574	2,864	3,682	2,867	869	2,019
80	2,656	2,956	3,798	2,959	897	2,087
81	2,738	3,048	3,918	3,050	925	2,151
82	2,821	3,138	4,035	3,142	952	2,217
83	2,908	3,234	4,159	3,240	981	2,285
84	2,992	3,329	4,280	3,333	1,009	2,352
85	3,100	3,450	4,434	3,455	1,047	2,437
86	3,191	3,550	4,562	3,555	1,076	2,506
87	3,280	3,651	4,690	3,654	1,107	2,578
88	3,373	3,751	4,824	3,757	1,138	2,649
89	3,466	3,854	4,958	3,861	1,169	2,724
90	3,560	3,963	5,093	3,967	1,202	2,799
91	3,658	4,070	5,233	4,075	1,235	2,874
92	3,757	4,178	5,373	4,185	1,269	2,952
93	3,858	4,290	5,517	4,298	1,302	3,031
94	3,961	4,403	5,662	4,411	1,337	3,111
95	4,063	4,520	5,809	4,526	1,371	3,193
96	4,169	4,635	5,962	4,641	1,406	3,275
97	4,274	4,752	6,113	4,762	1,442	3,359
98	4,382	4,874	6,268	4,882	1,479	3,443
99+	4,491	4,997	6,424	5,003	1,515	3,529

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	2,008	2,233	2,871	2,238	678	1,490
65	2,008	2,233	2,871	2,238	678	1,490
66	2,008	2,233	2,871	2,238	678	1,490
67	2,008	2,233	2,871	2,238	678	1,490
68	2,029	2,258	2,902	2,262	684	1,545
69	2,075	2,310	2,970	2,313	702	1,608
70	2,133	2,371	3,047	2,373	719	1,672
71	2,194	2,442	3,140	2,445	742	1,729
72	2,263	2,518	3,238	2,521	764	1,788
73	2,339	2,599	3,344	2,603	789	1,848
74	2,420	2,690	3,460	2,693	817	1,911
75	2,505	2,785	3,582	2,789	844	1,972
76	2,593	2,883	3,708	2,887	875	2,036
77	2,683	2,985	3,838	2,988	905	2,104
78	2,775	3,085	3,967	3,090	937	2,175
79	2,862	3,182	4,090	3,187	966	2,244
80	2,950	3,284	4,220	3,286	996	2,319
81	3,044	3,385	4,354	3,390	1,028	2,391
82	3,136	3,486	4,485	3,491	1,058	2,463
83	3,230	3,594	4,620	3,600	1,090	2,540
84	3,324	3,699	4,757	3,704	1,121	2,613
85	3,447	3,833	4,928	3,839	1,163	2,708
86	3,544	3,943	5,070	3,948	1,195	2,784
87	3,644	4,055	5,213	4,059	1,230	2,866
88	3,745	4,166	5,361	4,175	1,265	2,944
89	3,849	4,283	5,509	4,289	1,300	3,027
90	3,956	4,402	5,658	4,409	1,335	3,109
91	4,066	4,521	5,814	4,530	1,373	3,194
92	4,175	4,641	5,971	4,651	1,410	3,279
93	4,284	4,767	6,131	4,775	1,447	3,368
94	4,400	4,894	6,292	4,900	1,486	3,456
95	4,514	5,022	6,457	5,029	1,524	3,546
96	4,631	5,151	6,623	5,157	1,562	3,639
97	4,747	5,281	6,790	5,290	1,602	3,730
98	4,868	5,415	6,964	5,424	1,644	3,827
99+	4,992	5,551	7,137	5,560	1,684	3,922

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 6/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	2,077	2,313	2,972	2,315	702	1,544
65	2,077	2,313	2,972	2,315	702	1,544
66	2,077	2,313	2,972	2,315	702	1,544
67	2,077	2,313	2,972	2,315	702	1,544
68	2,101	2,337	3,005	2,340	709	1,597
69	2,149	2,391	3,073	2,393	725	1,665
70	2,207	2,453	3,153	2,458	744	1,730
71	2,270	2,526	3,249	2,530	768	1,789
72	2,342	2,606	3,352	2,609	790	1,851
73	2,420	2,690	3,461	2,693	816	1,911
74	2,504	2,785	3,582	2,789	846	1,979
75	2,593	2,883	3,708	2,885	874	2,041
76	2,682	2,985	3,835	2,988	905	2,106
77	2,778	3,090	3,974	3,094	937	2,177
78	2,869	3,194	4,106	3,198	970	2,251
79	2,961	3,292	4,233	3,298	999	2,324
80	3,052	3,398	4,367	3,403	1,030	2,401
81	3,151	3,504	4,506	3,509	1,064	2,475
82	3,244	3,608	4,639	3,615	1,095	2,551
83	3,344	3,720	4,784	3,724	1,128	2,629
84	3,443	3,830	4,923	3,833	1,161	2,704
85	3,565	3,967	5,098	3,974	1,204	2,804
86	3,668	4,081	5,246	4,088	1,238	2,882
87	3,772	4,199	5,395	4,202	1,273	2,964
88	3,879	4,311	5,547	4,321	1,309	3,048
89	3,985	4,433	5,700	4,439	1,344	3,133
90	4,096	4,557	5,858	4,563	1,381	3,219
91	4,205	4,677	6,018	4,687	1,420	3,306
92	4,321	4,804	6,181	4,815	1,458	3,395
93	4,434	4,934	6,346	4,943	1,498	3,484
94	4,553	5,065	6,511	5,073	1,538	3,577
95	4,672	5,198	6,681	5,206	1,577	3,670
96	4,793	5,330	6,855	5,339	1,617	3,767
97	4,914	5,466	7,030	5,476	1,658	3,861
98	5,037	5,602	7,208	5,615	1,701	3,962
99+	5,165	5,747	7,389	5,754	1,742	4,060

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	2,306	2,568	3,303	2,573	780	1,715
65	2,306	2,568	3,303	2,573	780	1,715
66	2,306	2,568	3,303	2,573	780	1,715
67	2,306	2,568	3,303	2,573	780	1,715
68	2,332	2,598	3,337	2,599	787	1,777
69	2,387	2,656	3,414	2,659	807	1,850
70	2,450	2,727	3,503	2,730	827	1,922
71	2,523	2,807	3,610	2,811	853	1,989
72	2,603	2,895	3,724	2,898	878	2,057
73	2,688	2,988	3,846	2,992	906	2,123
74	2,781	3,095	3,978	3,098	940	2,199
75	2,882	3,203	4,119	3,205	971	2,268
76	2,982	3,316	4,263	3,321	1,007	2,341
77	3,088	3,430	4,413	3,436	1,042	2,420
78	3,191	3,550	4,562	3,555	1,078	2,501
79	3,291	3,660	4,705	3,664	1,111	2,582
80	3,394	3,776	4,853	3,781	1,145	2,668
81	3,501	3,892	5,005	3,900	1,182	2,749
82	3,606	4,011	5,156	4,016	1,216	2,833
83	3,715	4,132	5,313	4,140	1,254	2,920
84	3,825	4,254	5,470	4,258	1,290	3,006
85	3,963	4,407	5,668	4,414	1,338	3,115
86	4,075	4,533	5,830	4,541	1,375	3,202
87	4,192	4,665	5,993	4,670	1,415	3,295
88	4,308	4,793	6,164	4,801	1,455	3,384
89	4,429	4,925	6,335	4,931	1,494	3,481
90	4,550	5,062	6,508	5,070	1,536	3,576
91	4,674	5,199	6,684	5,208	1,579	3,674
92	4,801	5,341	6,865	5,348	1,622	3,771
93	4,928	5,485	7,049	5,492	1,664	3,873
94	5,058	5,627	7,234	5,636	1,709	3,975
95	5,189	5,773	7,425	5,783	1,752	4,078
96	5,327	5,922	7,616	5,931	1,797	4,185
97	5,460	6,076	7,811	6,083	1,843	4,290
98	5,599	6,226	8,008	6,238	1,891	4,400
99+	5,741	6,386	8,209	6,393	1,937	4,510

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 6/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,456	1,621	2,084	1,623	492	1,082
65	1,456	1,621	2,084	1,623	492	1,082
66	1,456	1,621	2,084	1,623	492	1,082
67	1,456	1,621	2,084	1,623	492	1,082
68	1,473	1,638	2,107	1,642	497	1,122
69	1,505	1,676	2,154	1,679	509	1,167
70	1,547	1,721	2,212	1,723	522	1,213
71	1,594	1,771	2,279	1,775	538	1,255
72	1,644	1,828	2,351	1,829	554	1,298
73	1,697	1,887	2,426	1,889	572	1,341
74	1,755	1,953	2,511	1,955	593	1,388
75	1,818	2,021	2,600	2,024	613	1,432
76	1,881	2,093	2,690	2,095	635	1,477
77	1,948	2,166	2,785	2,168	657	1,527
78	2,014	2,240	2,880	2,242	680	1,578
79	2,076	2,310	2,969	2,312	701	1,628
80	2,142	2,384	3,063	2,386	723	1,683
81	2,208	2,458	3,160	2,460	746	1,735
82	2,275	2,531	3,254	2,534	768	1,788
83	2,345	2,608	3,354	2,613	791	1,843
84	2,413	2,685	3,452	2,688	814	1,897
85	2,500	2,782	3,576	2,786	844	1,965
86	2,573	2,863	3,679	2,867	868	2,021
87	2,645	2,944	3,782	2,947	893	2,079
88	2,720	3,025	3,890	3,030	918	2,136
89	2,795	3,108	3,998	3,114	943	2,197
90	2,871	3,196	4,107	3,199	969	2,257
91	2,950	3,282	4,220	3,286	996	2,318
92	3,030	3,369	4,333	3,375	1,023	2,381
93	3,111	3,460	4,449	3,466	1,050	2,444
94	3,194	3,551	4,566	3,557	1,078	2,509
95	3,277	3,645	4,685	3,650	1,106	2,575
96	3,362	3,738	4,808	3,743	1,134	2,641
97	3,447	3,832	4,930	3,840	1,163	2,709
98	3,534	3,931	5,055	3,937	1,193	2,777
99+	3,622	4,030	5,181	4,035	1,222	2,846

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,619	1,801	2,315	1,805	547	1,202
65	1,619	1,801	2,315	1,805	547	1,202
66	1,619	1,801	2,315	1,805	547	1,202
67	1,619	1,801	2,315	1,805	547	1,202
68	1,636	1,821	2,340	1,824	552	1,246
69	1,673	1,863	2,395	1,865	566	1,297
70	1,720	1,912	2,457	1,914	580	1,348
71	1,769	1,969	2,532	1,972	598	1,394
72	1,825	2,031	2,611	2,033	616	1,442
73	1,886	2,096	2,697	2,099	636	1,490
74	1,952	2,169	2,790	2,172	659	1,541
75	2,020	2,246	2,889	2,249	681	1,590
76	2,091	2,325	2,990	2,328	706	1,642
77	2,164	2,407	3,095	2,410	730	1,697
78	2,238	2,488	3,199	2,492	756	1,754
79	2,308	2,566	3,298	2,570	779	1,810
80	2,379	2,648	3,403	2,650	803	1,870
81	2,455	2,730	3,511	2,734	829	1,928
82	2,529	2,811	3,617	2,815	853	1,986
83	2,605	2,898	3,726	2,903	879	2,048
84	2,681	2,983	3,836	2,987	904	2,107
85	2,780	3,091	3,974	3,096	938	2,184
86	2,858	3,180	4,089	3,184	964	2,245
87	2,939	3,270	4,204	3,273	992	2,311
88	3,020	3,360	4,323	3,367	1,020	2,374
89	3,104	3,454	4,443	3,459	1,048	2,441
90	3,190	3,550	4,563	3,556	1,077	2,507
91	3,279	3,646	4,689	3,653	1,107	2,576
92	3,367	3,743	4,815	3,751	1,137	2,644
93	3,455	3,844	4,944	3,851	1,167	2,716
94	3,548	3,947	5,074	3,952	1,198	2,787
95	3,640	4,050	5,207	4,056	1,229	2,860
96	3,735	4,154	5,341	4,159	1,260	2,935
97	3,828	4,259	5,476	4,266	1,292	3,008
98	3,926	4,367	5,616	4,374	1,326	3,086
99+	4,026	4,477	5,756	4,484	1,358	3,163

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 6/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,675	1,865	2,397	1,867	566	1,245
65	1,675	1,865	2,397	1,867	566	1,245
66	1,675	1,865	2,397	1,867	566	1,245
67	1,675	1,865	2,397	1,867	566	1,245
68	1,694	1,885	2,423	1,887	572	1,288
69	1,733	1,928	2,478	1,930	585	1,343
70	1,780	1,978	2,543	1,982	600	1,395
71	1,831	2,037	2,620	2,040	619	1,443
72	1,889	2,102	2,703	2,104	637	1,493
73	1,952	2,169	2,791	2,172	658	1,541
74	2,019	2,246	2,889	2,249	682	1,596
75	2,091	2,325	2,990	2,327	705	1,646
76	2,163	2,407	3,093	2,410	730	1,698
77	2,240	2,492	3,205	2,495	756	1,756
78	2,314	2,576	3,311	2,579	782	1,815
79	2,388	2,655	3,414	2,660	806	1,874
80	2,461	2,740	3,522	2,744	831	1,936
81	2,541	2,826	3,634	2,830	858	1,996
82	2,616	2,910	3,741	2,915	883	2,057
83	2,697	3,000	3,858	3,003	910	2,120
84	2,777	3,089	3,970	3,091	936	2,181
85	2,875	3,199	4,111	3,205	971	2,261
86	2,958	3,291	4,231	3,297	998	2,324
87	3,042	3,386	4,351	3,389	1,027	2,390
88	3,128	3,477	4,473	3,485	1,056	2,458
89	3,214	3,575	4,597	3,580	1,084	2,527
90	3,303	3,675	4,724	3,680	1,114	2,596
91	3,391	3,772	4,853	3,780	1,145	2,666
92	3,485	3,874	4,985	3,883	1,176	2,738
93	3,576	3,979	5,118	3,986	1,208	2,810
94	3,672	4,085	5,251	4,091	1,240	2,885
95	3,768	4,192	5,388	4,198	1,272	2,960
96	3,865	4,298	5,528	4,306	1,304	3,038
97	3,963	4,408	5,669	4,416	1,337	3,114
98	4,062	4,518	5,813	4,528	1,372	3,195
99+	4,165	4,635	5,959	4,640	1,405	3,274

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,860	2,071	2,664	2,075	629	1,383
65	1,860	2,071	2,664	2,075	629	1,383
66	1,860	2,071	2,664	2,075	629	1,383
67	1,860	2,071	2,664	2,075	629	1,383
68	1,881	2,095	2,691	2,096	635	1,433
69	1,925	2,142	2,753	2,144	651	1,492
70	1,976	2,199	2,825	2,202	667	1,550
71	2,035	2,264	2,911	2,267	688	1,604
72	2,099	2,335	3,003	2,337	708	1,659
73	2,168	2,410	3,102	2,413	731	1,712
74	2,243	2,496	3,208	2,498	758	1,773
75	2,324	2,583	3,322	2,585	783	1,829
76	2,405	2,674	3,438	2,678	812	1,888
77	2,490	2,766	3,559	2,771	840	1,952
78	2,573	2,863	3,679	2,867	869	2,017
79	2,654	2,952	3,794	2,955	896	2,082
80	2,737	3,045	3,914	3,049	923	2,152
81	2,823	3,139	4,036	3,145	953	2,217
82	2,908	3,235	4,158	3,239	981	2,285
83	2,996	3,332	4,285	3,339	1,011	2,355
84	3,085	3,431	4,411	3,434	1,040	2,424
85	3,196	3,554	4,571	3,560	1,079	2,512
86	3,286	3,656	4,702	3,662	1,109	2,582
87	3,381	3,762	4,833	3,766	1,141	2,657
88	3,474	3,865	4,971	3,872	1,173	2,729
89	3,572	3,972	5,109	3,977	1,205	2,807
90	3,669	4,082	5,248	4,089	1,239	2,884
91	3,769	4,193	5,390	4,200	1,273	2,963
92	3,872	4,307	5,536	4,313	1,308	3,041
93	3,974	4,423	5,685	4,429	1,342	3,123
94	4,079	4,538	5,834	4,545	1,378	3,206
95	4,185	4,656	5,988	4,664	1,413	3,289
96	4,296	4,776	6,142	4,783	1,449	3,375
97	4,403	4,900	6,299	4,906	1,486	3,460
98	4,515	5,021	6,458	5,031	1,525	3,548
99+	4,630	5,150	6,620	5,156	1,562	3,637

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.

Plan G high deductible: this 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