Outline of coverage **Medicare Supplement Insurance**

Accendo Insurance Company

part of the CVS Health® family of companies and Aetna affiliate

Policy administered by Aetna Life Insurance Company and its affiliates

Illinois

Benefit plans: A, F, G, N

Rates effective: (03/2022 D)

ACCMS07467IL
(03/2022 D)

ACCENDO INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE
BENEFIT PLANS AVAILABLE: A, F, G, N

This chart shows the benefits included in each of the standard Medicare supplement plans. 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 2023 [2]					**$6,940[2]**	**$3,470[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,700** 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.

Accendo Insurance Company
Annual premiums
For use in ZIP Codes: 600-608
Female rates

Rates effective 3/1/2022

ATTAINED AGE	PREFERRED			
	Plan A	Plan F	Plan G	Plan N
Under 65	3,613	4,730	3,857	2,889
65	1,454	1,904	1,553	1,099
66	1,454	1,904	1,553	1,099
67	1,454	1,904	1,553	1,099
68	1,470	1,924	1,570	1,139
69	1,503	1,967	1,605	1,185
70	1,544	2,020	1,647	1,231
71	1,590	2,081	1,696	1,274
72	1,639	2,146	1,750	1,318
73	1,693	2,216	1,807	1,361
74	1,752	2,293	1,870	1,407
75	1,813	2,372	1,936	1,453
76	1,877	2,458	2,005	1,500
77	1,941	2,543	2,073	1,551
78	2,008	2,631	2,145	1,602
79	2,072	2,712	2,212	1,653
80	2,137	2,797	2,281	1,708
81	2,204	2,886	2,352	1,763
82	2,269	2,970	2,423	1,815
83	2,340	3,064	2,498	1,870
84	2,408	3,151	2,571	1,925
85	2,495	3,267	2,664	1,995
86	2,566	3,359	2,741	2,051
87	2,638	3,454	2,818	2,110
88	2,714	3,552	2,897	2,169
89	2,788	3,651	2,977	2,230
90	2,865	3,751	3,060	2,290
91	2,944	3,854	3,144	2,353
92	3,023	3,957	3,227	2,416
93	3,104	4,063	3,313	2,481
94	3,185	4,169	3,401	2,546
95	3,269	4,278	3,490	2,613
96	3,352	4,390	3,580	2,681
97	3,439	4,501	3,672	2,748
98	3,525	4,615	3,764	2,818
99+	3,613	4,730	3,857	2,889

ATTAINED AGE	STANDARD			
	Plan A	Plan F	Plan G	Plan N
Under 65	4,015	5,256	4,287	3,210
65	1,616	2,113	1,725	1,221
66	1,616	2,113	1,725	1,221
67	1,616	2,113	1,725	1,221
68	1,634	2,137	1,744	1,265
69	1,669	2,187	1,784	1,318
70	1,716	2,244	1,830	1,368
71	1,766	2,312	1,886	1,415
72	1,820	2,384	1,944	1,464
73	1,880	2,462	2,007	1,513
74	1,947	2,549	2,079	1,564
75	2,015	2,637	2,151	1,615
76	2,085	2,729	2,227	1,667
77	2,159	2,825	2,305	1,723
78	2,232	2,922	2,383	1,779
79	2,302	3,013	2,458	1,837
80	2,374	3,108	2,534	1,898
81	2,449	3,205	2,614	1,958
82	2,520	3,301	2,693	2,017
83	2,600	3,403	2,774	2,078
84	2,675	3,503	2,856	2,138
85	2,772	3,630	2,960	2,216
86	2,850	3,733	3,045	2,280
87	2,932	3,837	3,131	2,344
88	3,015	3,947	3,220	2,410
89	3,098	4,056	3,308	2,478
90	3,183	4,167	3,400	2,544
91	3,270	4,282	3,492	2,614
92	3,358	4,397	3,585	2,684
93	3,449	4,514	3,681	2,757
94	3,539	4,633	3,778	2,829
95	3,632	4,754	3,877	2,904
96	3,725	4,877	3,977	2,979
97	3,821	5,002	4,079	3,054
98	3,916	5,129	4,181	3,131
99+	4,015	5,256	4,287	3,210

The above rates do not include the $25 one-time policy fee.

To calculate the 14% household discount:

Annual premium **x** modal factor **= modal premium** (round to nearest whole cent)
Modal premium **x** .86 **= discounted premium**

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

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

Accendo Insurance Company
Annual premiums
For use in ZIP Codes: 600-608
Male rates

Rates effective 3/1/2022

ATTAINED AGE	PREFERRED			
	Plan A	Plan F	Plan G	Plan N
Under 65	4,156	5,439	4,437	3,323
65	1,673	2,189	1,785	1,263
66	1,673	2,189	1,785	1,263
67	1,673	2,189	1,785	1,263
68	1,692	2,212	1,805	1,310
69	1,728	2,262	1,845	1,364
70	1,775	2,323	1,894	1,415
71	1,828	2,393	1,951	1,465
72	1,885	2,468	2,012	1,515
73	1,947	2,549	2,078	1,565
74	2,015	2,637	2,151	1,618
75	2,085	2,728	2,227	1,672
76	2,159	2,825	2,305	1,725
77	2,233	2,925	2,385	1,784
78	2,310	3,025	2,468	1,841
79	2,383	3,118	2,544	1,901
80	2,458	3,217	2,623	1,965
81	2,535	3,319	2,704	2,027
82	2,610	3,415	2,787	2,088
83	2,691	3,523	2,873	2,151
84	2,768	3,625	2,955	2,213
85	2,869	3,756	3,062	2,293
86	2,951	3,863	3,151	2,359
87	3,035	3,972	3,241	2,426
88	3,120	4,085	3,331	2,494
89	3,207	4,197	3,423	2,564
90	3,294	4,313	3,520	2,634
91	3,386	4,431	3,615	2,706
92	3,477	4,550	3,712	2,778
93	3,568	4,673	3,810	2,853
94	3,662	4,795	3,911	2,929
95	3,760	4,921	4,013	3,005
96	3,856	5,047	4,118	3,082
97	3,955	5,176	4,224	3,161
98	4,055	5,308	4,329	3,241
99+	4,156	5,439	4,437	3,323

ATTAINED AGE	STANDARD			
	Plan A	Plan F	Plan G	Plan N
Under 65	4,616	6,045	4,931	3,691
65	1,858	2,432	1,984	1,404
66	1,858	2,432	1,984	1,404
67	1,858	2,432	1,984	1,404
68	1,879	2,458	2,007	1,455
69	1,920	2,514	2,052	1,515
70	1,974	2,582	2,105	1,572
71	2,031	2,660	2,169	1,627
72	2,093	2,743	2,236	1,683
73	2,162	2,832	2,308	1,740
74	2,239	2,930	2,391	1,798
75	2,317	3,033	2,473	1,858
76	2,396	3,140	2,561	1,917
77	2,483	3,250	2,651	1,981
78	2,567	3,360	2,741	2,047
79	2,647	3,464	2,826	2,112
80	2,729	3,575	2,914	2,183
81	2,817	3,685	3,007	2,252
82	2,899	3,795	3,097	2,320
83	2,990	3,914	3,191	2,390
84	3,077	4,029	3,283	2,458
85	3,187	4,175	3,403	2,547
86	3,279	4,292	3,502	2,621
87	3,372	4,413	3,601	2,696
88	3,467	4,540	3,703	2,772
89	3,563	4,664	3,804	2,849
90	3,661	4,792	3,909	2,926
91	3,761	4,924	4,016	3,006
92	3,861	5,056	4,124	3,086
93	3,965	5,190	4,232	3,171
94	4,070	5,328	4,346	3,255
95	4,177	5,467	4,459	3,339
96	4,285	5,609	4,574	3,425
97	4,394	5,752	4,691	3,512
98	4,503	5,899	4,809	3,602
99+	4,616	6,045	4,931	3,691

The above rates do not include the $25 application fee.

To calculate the 14% household discount:

Annual premium **x** modal factor **= modal premium** (round to nearest whole cent)
Modal premium **x** .86 **= 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

Accendo Insurance Company

Annual premiums

For use in: Rest of State

Female rates

Rates effective 3/1/2022

ATTAINED AGE	PREFERRED			
	Plan A	Plan F	Plan G	Plan N
Under 65	3,255	4,261	3,475	2,603
65	1,310	1,715	1,399	990
66	1,310	1,715	1,399	990
67	1,310	1,715	1,399	990
68	1,324	1,733	1,414	1,026
69	1,354	1,772	1,446	1,068
70	1,391	1,820	1,484	1,109
71	1,432	1,875	1,528	1,148
72	1,477	1,933	1,577	1,187
73	1,525	1,996	1,628	1,226
74	1,578	2,066	1,685	1,268
75	1,633	2,137	1,744	1,309
76	1,691	2,214	1,806	1,351
77	1,749	2,291	1,868	1,397
78	1,809	2,370	1,932	1,443
79	1,867	2,443	1,993	1,489
80	1,925	2,520	2,055	1,539
81	1,986	2,600	2,119	1,588
82	2,044	2,676	2,183	1,635
83	2,108	2,760	2,250	1,685
84	2,169	2,839	2,316	1,734
85	2,248	2,943	2,400	1,797
86	2,312	3,026	2,469	1,848
87	2,377	3,112	2,539	1,901
88	2,445	3,200	2,610	1,954
89	2,512	3,289	2,682	2,009
90	2,581	3,379	2,757	2,063
91	2,652	3,472	2,832	2,120
92	2,723	3,565	2,907	2,177
93	2,796	3,660	2,985	2,235
94	2,869	3,756	3,064	2,294
95	2,945	3,854	3,144	2,354
96	3,020	3,955	3,225	2,415
97	3,098	4,055	3,308	2,476
98	3,176	4,158	3,391	2,539
99+	3,255	4,261	3,475	2,603

ATTAINED AGE	STANDARD			
	Plan A	Plan F	Plan G	Plan N
Under 65	3,617	4,735	3,862	2,892
65	1,456	1,904	1,554	1,100
66	1,456	1,904	1,554	1,100
67	1,456	1,904	1,554	1,100
68	1,472	1,925	1,571	1,140
69	1,504	1,970	1,607	1,187
70	1,546	2,022	1,649	1,232
71	1,591	2,083	1,699	1,275
72	1,640	2,148	1,751	1,319
73	1,694	2,218	1,808	1,363
74	1,754	2,296	1,873	1,409
75	1,815	2,376	1,938	1,455
76	1,878	2,459	2,006	1,502
77	1,945	2,545	2,077	1,552
78	2,011	2,632	2,147	1,603
79	2,074	2,714	2,214	1,655
80	2,139	2,800	2,283	1,710
81	2,206	2,887	2,355	1,764
82	2,270	2,974	2,426	1,817
83	2,342	3,066	2,499	1,872
84	2,410	3,156	2,573	1,926
85	2,497	3,270	2,667	1,996
86	2,568	3,363	2,743	2,054
87	2,641	3,457	2,821	2,112
88	2,716	3,556	2,901	2,171
89	2,791	3,654	2,980	2,232
90	2,868	3,754	3,063	2,292
91	2,946	3,858	3,146	2,355
92	3,025	3,961	3,230	2,418
93	3,107	4,067	3,316	2,484
94	3,188	4,174	3,404	2,549
95	3,272	4,283	3,493	2,616
96	3,356	4,394	3,583	2,684
97	3,442	4,506	3,675	2,751
98	3,528	4,621	3,767	2,821
99+	3,617	4,735	3,862	2,892

The above rates do not include the $25 application fee.

To calculate the 14% household discount:

Annual premium **x** modal factor **= modal premium** (round to nearest whole cent)

Modal premium **x** .86 **= discounted premium**

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

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

Accendo Insurance Company

Annual premiums

For use in: Rest of State

Male rates

Rates effective 3/1/2022

ATTAINED AGE	PREFERRED			
	Plan A	Plan F	Plan G	Plan N
Under 65	3,744	4,900	3,997	2,994
65	1,507	1,972	1,608	1,138
66	1,507	1,972	1,608	1,138
67	1,507	1,972	1,608	1,138
68	1,524	1,993	1,626	1,180
69	1,557	2,038	1,662	1,229
70	1,599	2,093	1,706	1,275
71	1,647	2,156	1,758	1,320
72	1,698	2,223	1,813	1,365
73	1,754	2,296	1,872	1,410
74	1,815	2,376	1,938	1,458
75	1,878	2,458	2,006	1,506
76	1,945	2,545	2,077	1,554
77	2,012	2,635	2,149	1,607
78	2,081	2,725	2,223	1,659
79	2,147	2,809	2,292	1,713
80	2,214	2,898	2,363	1,770
81	2,284	2,990	2,436	1,826
82	2,351	3,077	2,511	1,881
83	2,424	3,174	2,588	1,938
84	2,494	3,266	2,662	1,994
85	2,585	3,384	2,759	2,066
86	2,659	3,480	2,839	2,125
87	2,734	3,578	2,920	2,186
88	2,811	3,680	3,001	2,247
89	2,889	3,781	3,084	2,310
90	2,968	3,886	3,171	2,373
91	3,050	3,992	3,257	2,438
92	3,132	4,099	3,344	2,503
93	3,214	4,210	3,432	2,570
94	3,299	4,320	3,523	2,639
95	3,387	4,433	3,615	2,707
96	3,474	4,547	3,710	2,777
97	3,563	4,663	3,805	2,848
98	3,653	4,782	3,900	2,920
99+	3,744	4,900	3,997	2,994

ATTAINED AGE	STANDARD			
	Plan A	Plan F	Plan G	Plan N
Under 65	4,159	5,446	4,442	3,325
65	1,674	2,191	1,787	1,265
66	1,674	2,191	1,787	1,265
67	1,674	2,191	1,787	1,265
68	1,693	2,214	1,808	1,311
69	1,730	2,265	1,849	1,365
70	1,778	2,326	1,896	1,416
71	1,830	2,396	1,954	1,466
72	1,886	2,471	2,014	1,516
73	1,948	2,551	2,079	1,568
74	2,017	2,640	2,154	1,620
75	2,087	2,732	2,228	1,674
76	2,159	2,829	2,307	1,727
77	2,237	2,928	2,388	1,785
78	2,313	3,027	2,469	1,844
79	2,385	3,121	2,546	1,903
80	2,459	3,221	2,625	1,967
81	2,538	3,320	2,709	2,029
82	2,612	3,419	2,790	2,090
83	2,694	3,526	2,875	2,153
84	2,772	3,630	2,958	2,214
85	2,871	3,761	3,066	2,295
86	2,954	3,867	3,155	2,361
87	3,038	3,976	3,244	2,429
88	3,123	4,090	3,336	2,497
89	3,210	4,202	3,427	2,567
90	3,298	4,317	3,522	2,636
91	3,388	4,436	3,618	2,708
92	3,478	4,555	3,715	2,780
93	3,572	4,676	3,813	2,857
94	3,667	4,800	3,915	2,932
95	3,763	4,925	4,017	3,008
96	3,860	5,053	4,121	3,086
97	3,959	5,182	4,226	3,164
98	4,057	5,314	4,332	3,245
99+	4,159	5,446	4,442	3,325

The above rates do not include the $25 application fee.

To calculate the 14% household discount:

Annual premium **x** modal factor **= modal premium** (round to nearest whole cent)

Modal premium **x** .86 **= discounted premium**

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

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

PREMIUM INFORMATION

Accendo 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

You are eligible for a Household Premium Discount if: (1) you reside with your spouse (including civil/domestic partner) or (2) for the past year you have resided with up to three adults age 60 or older. For the purpose of this discount, a civil union partner or domestic partner will be considered a legal spouse when partnerships are valid and recognized in your state of residence. We may request additional documentation to determine eligibility. The discounted rates will be 14 percent lower than the individual rates and will be removed if the other adult or spouse no longer resides with you (other than in the case of his/her death).

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 Accendo 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 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 Accendo 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, F, G, and N OFFERED BY ACCENDO 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 $1,600	$0	$1,600 (Part A Deductible)
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	$0	Up to $200 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 $226 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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $1,600	$1,600 (Part A Deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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 $226 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 $226 of Medicare-Approved amounts*	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$226 (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 $1,600	$1,600 (Part A Deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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 $226 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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$0	$226 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,600	$1,600 (Part A Deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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 $226 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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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 $226 of Medicare-Approved amounts*	$0	$0	$226 (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