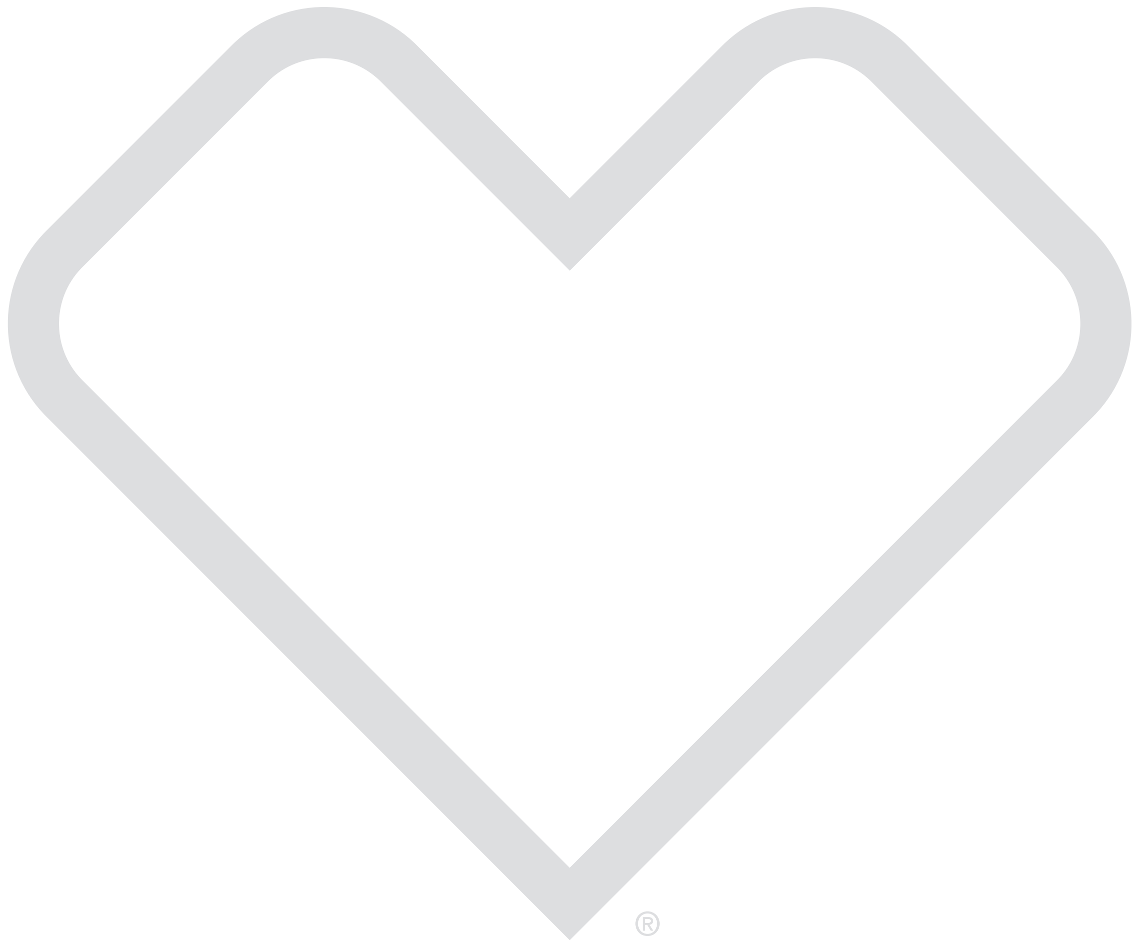

Outline of coverage
Medicare Supplement Insurance

Accendo Insurance Company

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

Policy administered by Aetna Life Insurance Company and its affiliates

Alabama

Benefit plans: A, F, G, N

Rates effective: (05/2022 A)

ACCMS05929AL
(05/2022 A)

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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 2022[2]					**$6,620**[2]	**$3,310**[2]				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,490 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: 350-352

Female Rates

Rates Effective 5/1/2022

Attained Age	Preferred Plan A	Preferred Plan F	Preferred Plan G	Preferred Plan N
65	1,618	1,994	1,848	1,558
66	1,618	1,994	1,848	1,558
67	1,618	1,994	1,848	1,558
68	1,643	2,027	1,877	1,623
69	1,677	2,068	1,914	1,685
70	1,719	2,120	1,964	1,747
71	1,773	2,185	2,025	1,811
72	1,828	2,254	2,088	1,872
73	1,888	2,328	2,156	1,936
74	1,954	2,409	2,233	2,002
75	2,023	2,494	2,311	2,066
76	2,094	2,582	2,391	2,132
77	2,167	2,672	2,475	2,204
78	2,237	2,758	2,556	2,275
79	2,306	2,845	2,635	2,346
80	2,380	2,935	2,718	2,426
81	2,454	3,027	2,804	2,501
82	2,531	3,121	2,892	2,579
83	2,613	3,223	2,985	2,663
84	2,698	3,327	3,080	2,749
85	2,780	3,426	3,174	2,832
86	2,859	3,526	3,265	2,913
87	2,940	3,625	3,358	2,996
88	3,023	3,727	3,452	3,079
89	3,106	3,831	3,547	3,166
90	3,191	3,935	3,645	3,252
91	3,279	4,042	3,745	3,341
92	3,367	4,152	3,845	3,431
93	3,457	4,262	3,948	3,523
94	3,547	4,375	4,051	3,615
95	3,641	4,489	4,157	3,711
96	3,735	4,606	4,266	3,806
97	3,831	4,723	4,374	3,903
98	3,927	4,842	4,485	4,001
99+	4,025	4,963	4,598	4,102

Attained Age	Standard Plan A	Standard Plan F	Standard Plan G	Standard Plan N
65	1,797	2,216	2,052	1,732
66	1,797	2,216	2,052	1,732
67	1,797	2,216	2,052	1,732
68	1,826	2,253	2,086	1,802
69	1,863	2,297	2,128	1,872
70	1,910	2,355	2,181	1,941
71	1,970	2,430	2,250	2,013
72	2,032	2,505	2,320	2,081
73	2,097	2,587	2,396	2,150
74	2,172	2,677	2,480	2,224
75	2,248	2,771	2,567	2,295
76	2,327	2,868	2,656	2,370
77	2,408	2,970	2,749	2,448
78	2,486	3,065	2,840	2,527
79	2,563	3,163	2,928	2,607
80	2,644	3,260	3,019	2,695
81	2,727	3,364	3,115	2,780
82	2,814	3,468	3,213	2,866
83	2,903	3,581	3,318	2,958
84	2,998	3,696	3,423	3,054
85	3,088	3,807	3,527	3,146
86	3,176	3,918	3,628	3,236
87	3,267	4,028	3,731	3,329
88	3,359	4,141	3,836	3,422
89	3,452	4,257	3,943	3,518
90	3,546	4,373	4,050	3,613
91	3,643	4,492	4,160	3,713
92	3,740	4,613	4,273	3,813
93	3,841	4,736	4,387	3,914
94	3,943	4,861	4,502	4,017
95	4,045	4,989	4,619	4,122
96	4,150	5,118	4,739	4,228
97	4,257	5,248	4,860	4,337
98	4,363	5,380	4,982	4,447
99+	4,471	5,514	5,109	4,557

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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

To calculate a 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 Period, use Preferred rates.

Accendo Insurance Company

Annual Premiums

For Use in ZIP Codes: 350-352

Male Rates

Rates Effective 5/1/2022

Attained	Preferred				Attained	Standard			
Age	Plan A	Plan F	Plan G	Plan N	Age	Plan A	Plan F	Plan G	Plan N
65	1,861	2,294	2,124	1,792	65	2,067	2,549	2,359	1,991
66	1,861	2,294	2,124	1,792	66	2,067	2,549	2,359	1,991
67	1,861	2,294	2,124	1,792	67	2,067	2,549	2,359	1,991
68	1,890	2,331	2,159	1,866	68	2,100	2,591	2,399	2,072
69	1,929	2,379	2,202	1,938	69	2,142	2,642	2,446	2,154
70	1,978	2,437	2,258	2,009	70	2,197	2,707	2,509	2,233
71	2,039	2,514	2,329	2,083	71	2,265	2,793	2,588	2,314
72	2,103	2,593	2,401	2,154	72	2,337	2,880	2,668	2,393
73	2,171	2,677	2,479	2,225	73	2,411	2,974	2,755	2,474
74	2,248	2,771	2,567	2,302	74	2,497	3,078	2,853	2,558
75	2,327	2,868	2,657	2,375	75	2,585	3,187	2,953	2,640
76	2,408	2,970	2,749	2,452	76	2,676	3,298	3,054	2,724
77	2,492	3,072	2,845	2,533	77	2,769	3,415	3,161	2,815
78	2,572	3,173	2,939	2,615	78	2,859	3,524	3,266	2,906
79	2,652	3,272	3,031	2,698	79	2,947	3,637	3,367	2,998
80	2,738	3,374	3,126	2,790	80	3,041	3,749	3,471	3,100
81	2,823	3,482	3,224	2,876	81	3,136	3,869	3,583	3,196
82	2,911	3,590	3,326	2,965	82	3,235	3,989	3,694	3,295
83	3,005	3,706	3,434	3,062	83	3,338	4,119	3,815	3,402
84	3,103	3,826	3,543	3,161	84	3,448	4,251	3,936	3,513
85	3,196	3,941	3,650	3,257	85	3,552	4,379	4,057	3,617
86	3,287	4,053	3,755	3,349	86	3,652	4,505	4,173	3,722
87	3,381	4,169	3,862	3,445	87	3,757	4,632	4,292	3,828
88	3,477	4,285	3,970	3,541	88	3,863	4,763	4,412	3,935
89	3,572	4,406	4,079	3,641	89	3,970	4,895	4,534	4,044
90	3,670	4,526	4,192	3,739	90	4,078	5,030	4,658	4,155
91	3,771	4,649	4,306	3,843	91	4,190	5,165	4,783	4,270
92	3,873	4,774	4,423	3,946	92	4,302	5,304	4,914	4,384
93	3,975	4,901	4,540	4,051	93	4,417	5,445	5,044	4,501
94	4,079	5,032	4,659	4,157	94	4,534	5,591	5,177	4,619
95	4,187	5,163	4,781	4,267	95	4,652	5,737	5,312	4,740
96	4,295	5,297	4,905	4,378	96	4,773	5,886	5,450	4,862
97	4,406	5,432	5,031	4,488	97	4,895	6,035	5,589	4,988
98	4,515	5,569	5,157	4,602	98	5,017	6,186	5,730	5,113
99+	4,628	5,708	5,287	4,718	99+	5,143	6,342	5,874	5,241

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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

To calculate a 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 Period, use Preferred rates.

Accendo Insurance Company

Annual Premiums

For Use in: Rest of State

Female Rates

Rates Effective 5/1/2022

Attained	Preferred			
Age	Plan A	Plan F	Plan G	Plan N
65	1,432	1,765	1,635	1,379
66	1,432	1,765	1,635	1,379
67	1,432	1,765	1,635	1,379
68	1,454	1,794	1,661	1,436
69	1,484	1,830	1,694	1,491
70	1,521	1,876	1,738	1,546
71	1,569	1,934	1,792	1,603
72	1,618	1,995	1,848	1,657
73	1,671	2,060	1,908	1,713
74	1,729	2,132	1,976	1,772
75	1,790	2,207	2,045	1,828
76	1,853	2,285	2,116	1,887
77	1,918	2,365	2,190	1,950
78	1,980	2,441	2,262	2,013
79	2,041	2,518	2,332	2,076
80	2,106	2,597	2,405	2,147
81	2,172	2,679	2,481	2,213
82	2,240	2,762	2,559	2,282
83	2,312	2,852	2,642	2,357
84	2,388	2,944	2,726	2,433
85	2,460	3,032	2,809	2,506
86	2,530	3,120	2,889	2,578
87	2,602	3,208	2,972	2,651
88	2,675	3,298	3,055	2,725
89	2,749	3,390	3,139	2,802
90	2,824	3,482	3,226	2,878
91	2,902	3,577	3,314	2,957
92	2,980	3,674	3,403	3,036
93	3,059	3,772	3,494	3,118
94	3,139	3,872	3,585	3,199
95	3,222	3,973	3,679	3,284
96	3,305	4,076	3,775	3,368
97	3,390	4,180	3,871	3,454
98	3,475	4,285	3,969	3,541
99+	3,562	4,392	4,069	3,630

Attained	Standard			
Age	Plan A	Plan F	Plan G	Plan N
65	1,590	1,961	1,816	1,533
66	1,590	1,961	1,816	1,533
67	1,590	1,961	1,816	1,533
68	1,616	1,994	1,846	1,595
69	1,649	2,033	1,883	1,657
70	1,690	2,084	1,930	1,718
71	1,743	2,150	1,991	1,781
72	1,798	2,217	2,053	1,842
73	1,856	2,289	2,120	1,903
74	1,922	2,369	2,195	1,968
75	1,989	2,452	2,272	2,031
76	2,059	2,538	2,350	2,097
77	2,131	2,628	2,433	2,166
78	2,200	2,712	2,513	2,236
79	2,268	2,799	2,591	2,307
80	2,340	2,885	2,672	2,385
81	2,413	2,977	2,757	2,460
82	2,490	3,069	2,843	2,536
83	2,569	3,169	2,936	2,618
84	2,653	3,271	3,029	2,703
85	2,733	3,369	3,121	2,784
86	2,811	3,467	3,211	2,864
87	2,891	3,565	3,302	2,946
88	2,973	3,665	3,395	3,028
89	3,055	3,767	3,489	3,113
90	3,138	3,870	3,584	3,197
91	3,224	3,975	3,681	3,286
92	3,310	4,082	3,781	3,374
93	3,399	4,191	3,882	3,464
94	3,489	4,302	3,984	3,555
95	3,580	4,415	4,088	3,648
96	3,673	4,529	4,194	3,742
97	3,767	4,644	4,301	3,838
98	3,861	4,761	4,409	3,935
99+	3,957	4,880	4,521	4,033

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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

To calculate a 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 Period, use Preferred rates.

Accendo Insurance Company

Annual Premiums

For Use in: Rest of State

Male Rates

Rates Effective 5/1/2022

Attained Age	Preferred				Attained Age	Standard			
	Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
65	1,647	2,030	1,880	1,586	65	1,829	2,256	2,088	1,762
66	1,647	2,030	1,880	1,586	66	1,829	2,256	2,088	1,762
67	1,647	2,030	1,880	1,586	67	1,829	2,256	2,088	1,762
68	1,673	2,063	1,911	1,651	68	1,858	2,293	2,123	1,834
69	1,707	2,105	1,949	1,715	69	1,896	2,338	2,165	1,906
70	1,750	2,157	1,998	1,778	70	1,944	2,396	2,220	1,976
71	1,804	2,225	2,061	1,843	71	2,004	2,472	2,290	2,048
72	1,861	2,295	2,125	1,906	72	2,068	2,549	2,361	2,118
73	1,921	2,369	2,194	1,969	73	2,134	2,632	2,438	2,189
74	1,989	2,452	2,272	2,037	74	2,210	2,724	2,525	2,264
75	2,059	2,538	2,351	2,102	75	2,288	2,820	2,613	2,336
76	2,131	2,628	2,433	2,170	76	2,368	2,919	2,703	2,411
77	2,205	2,719	2,518	2,242	77	2,450	3,022	2,797	2,491
78	2,276	2,808	2,601	2,314	78	2,530	3,119	2,890	2,572
79	2,347	2,896	2,682	2,388	79	2,608	3,219	2,980	2,653
80	2,423	2,986	2,766	2,469	80	2,691	3,318	3,072	2,743
81	2,498	3,081	2,853	2,545	81	2,775	3,424	3,171	2,828
82	2,576	3,177	2,943	2,624	82	2,863	3,530	3,269	2,916
83	2,659	3,280	3,039	2,710	83	2,954	3,645	3,376	3,011
84	2,746	3,386	3,135	2,797	84	3,051	3,762	3,483	3,109
85	2,828	3,488	3,230	2,882	85	3,143	3,875	3,590	3,201
86	2,909	3,587	3,323	2,964	86	3,232	3,987	3,693	3,294
87	2,992	3,689	3,418	3,049	87	3,325	4,099	3,798	3,388
88	3,077	3,792	3,513	3,134	88	3,419	4,215	3,904	3,482
89	3,161	3,899	3,610	3,222	89	3,513	4,332	4,012	3,579
90	3,248	4,005	3,710	3,309	90	3,609	4,451	4,122	3,677
91	3,337	4,114	3,811	3,401	91	3,708	4,571	4,233	3,779
92	3,427	4,225	3,914	3,492	92	3,807	4,694	4,349	3,880
93	3,518	4,337	4,018	3,585	93	3,909	4,819	4,464	3,983
94	3,610	4,453	4,123	3,679	94	4,012	4,948	4,581	4,088
95	3,705	4,569	4,231	3,776	95	4,117	5,077	4,701	4,195
96	3,801	4,688	4,341	3,874	96	4,224	5,209	4,823	4,303
97	3,899	4,807	4,452	3,972	97	4,332	5,341	4,946	4,414
98	3,996	4,928	4,564	4,073	98	4,440	5,474	5,071	4,525
99+	4,096	5,051	4,679	4,175	99+	4,551	5,612	5,198	4,638

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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

To calculate a 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 Period, 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 union/domestic partner) or (2) for the past year you have resided with at least one, but not more than three, other adults. For the purpose of this discount, a civil union partner or domestic partner will be considered a legal spouse when such partnerships are valid and recognized in your state of residence. We may request additional documentation to determine eligibility. The discounted rate will be 14 percent lower than the individual rate 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 $1,556	$0	$1,556 (Part A Deductible)
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	$0	Up to $194.50 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 $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$0	$233 (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 $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 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 $233 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 test, durable medical equipment			
First $233 of Medicare-Approved amounts*	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$233 (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 $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 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 services	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 $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$0	$233 (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 $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
*While using 60 lifetime reserve days	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 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 services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ 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 $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 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.
Part B Excess Charges (Above Medicare-Approved amounts)	$0	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$0	$233 (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