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: 03/1/2020

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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 2020[2]					**$5,880[2]**	**$2,940[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,340 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 3/1/2020

Attained Age	Preferred Plan A	Plan F	Plan G	Plan N
Under 65	3,157	4,133	3,402	2,752
65	1,271	1,663	1,369	1,047
66	1,271	1,663	1,369	1,047
67	1,271	1,663	1,369	1,047
68	1,284	1,681	1,384	1,084
69	1,313	1,719	1,415	1,129
70	1,349	1,765	1,453	1,172
71	1,389	1,818	1,496	1,213
72	1,432	1,875	1,543	1,254
73	1,479	1,936	1,593	1,296
74	1,531	2,004	1,649	1,341
75	1,584	2,073	1,707	1,384
76	1,639	2,147	1,767	1,429
77	1,697	2,222	1,829	1,476
78	1,755	2,298	1,891	1,525
79	1,810	2,369	1,950	1,574
80	1,867	2,444	2,011	1,627
81	1,926	2,521	2,075	1,678
82	1,982	2,595	2,137	1,728
83	2,045	2,676	2,202	1,782
84	2,103	2,754	2,267	1,833
85	2,180	2,854	2,349	1,899
86	2,242	2,935	2,416	1,954
87	2,305	3,018	2,485	2,009
88	2,371	3,104	2,555	2,066
89	2,436	3,189	2,625	2,123
90	2,503	3,277	2,698	2,181
91	2,572	3,367	2,772	2,241
92	2,641	3,458	2,846	2,301
93	2,712	3,550	2,922	2,363
94	2,783	3,643	2,999	2,425
95	2,856	3,738	3,077	2,489
96	2,929	3,835	3,157	2,553
97	3,005	3,933	3,238	2,617
98	3,080	4,033	3,319	2,684
99+	3,157	4,133	3,402	2,752

Attained Age	Standard Plan A	Plan F	Plan G	Plan N
Under 65	3,508	4,592	3,781	3,057
65	1,412	1,847	1,521	1,163
66	1,412	1,847	1,521	1,163
67	1,412	1,847	1,521	1,163
68	1,427	1,867	1,538	1,205
69	1,459	1,910	1,573	1,254
70	1,499	1,961	1,614	1,302
71	1,543	2,020	1,663	1,348
72	1,591	2,083	1,714	1,394
73	1,643	2,151	1,769	1,441
74	1,701	2,227	1,833	1,490
75	1,760	2,304	1,897	1,538
76	1,822	2,385	1,964	1,587
77	1,886	2,469	2,032	1,641
78	1,950	2,553	2,101	1,695
79	2,011	2,632	2,167	1,749
80	2,075	2,716	2,234	1,808
81	2,140	2,801	2,305	1,865
82	2,202	2,884	2,374	1,920
83	2,272	2,974	2,446	1,979
84	2,338	3,060	2,519	2,036
85	2,422	3,171	2,610	2,110
86	2,491	3,261	2,685	2,171
87	2,562	3,353	2,762	2,232
88	2,634	3,449	2,839	2,295
89	2,707	3,543	2,917	2,360
90	2,782	3,641	2,998	2,423
91	2,857	3,741	3,079	2,490
92	2,934	3,842	3,162	2,556
93	3,013	3,944	3,246	2,626
94	3,092	4,048	3,332	2,695
95	3,173	4,154	3,419	2,765
96	3,255	4,261	3,508	2,837
97	3,339	4,370	3,598	2,908
98	3,422	4,481	3,687	2,983
99+	3,508	4,592	3,781	3,057

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 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: 600-608
Male Rates

Rates Effective 3/1/2020

Attained Age	Preferred Plan A	Plan F	Plan G	Plan N
Under 65	3,631	4,752	3,913	3,165
65	1,462	1,913	1,574	1,203
66	1,462	1,913	1,574	1,203
67	1,462	1,913	1,574	1,203
68	1,477	1,933	1,592	1,248
69	1,510	1,977	1,627	1,299
70	1,551	2,030	1,671	1,348
71	1,597	2,091	1,721	1,395
72	1,647	2,156	1,775	1,443
73	1,701	2,227	1,832	1,491
74	1,760	2,304	1,897	1,542
75	1,822	2,384	1,964	1,592
76	1,886	2,469	2,032	1,643
77	1,951	2,555	2,103	1,698
78	2,018	2,643	2,176	1,754
79	2,082	2,724	2,243	1,810
80	2,147	2,811	2,313	1,871
81	2,214	2,899	2,385	1,930
82	2,280	2,985	2,458	1,988
83	2,351	3,078	2,533	2,049
84	2,419	3,167	2,606	2,108
85	2,507	3,282	2,701	2,184
86	2,579	3,376	2,779	2,247
87	2,652	3,471	2,858	2,311
88	2,726	3,569	2,938	2,375
89	2,802	3,667	3,019	2,442
90	2,878	3,768	3,104	2,509
91	2,958	3,872	3,188	2,577
92	3,037	3,976	3,273	2,646
93	3,118	4,083	3,360	2,717
94	3,200	4,189	3,449	2,789
95	3,284	4,299	3,539	2,862
96	3,369	4,410	3,631	2,936
97	3,455	4,522	3,724	3,010
98	3,542	4,638	3,817	3,087
99+	3,631	4,752	3,913	3,165

Attained Age	Standard Plan A	Plan F	Plan G	Plan N
Under 65	4,034	5,281	4,348	3,515
65	1,624	2,125	1,749	1,338
66	1,624	2,125	1,749	1,338
67	1,624	2,125	1,749	1,338
68	1,642	2,147	1,769	1,386
69	1,677	2,197	1,809	1,443
70	1,724	2,256	1,856	1,497
71	1,775	2,323	1,913	1,550
72	1,829	2,396	1,971	1,603
73	1,889	2,474	2,035	1,657
74	1,956	2,561	2,108	1,713
75	2,025	2,650	2,181	1,769
76	2,095	2,743	2,258	1,826
77	2,169	2,839	2,338	1,887
78	2,243	2,936	2,416	1,949
79	2,313	3,027	2,492	2,011
80	2,385	3,124	2,570	2,079
81	2,461	3,220	2,652	2,145
82	2,533	3,317	2,731	2,209
83	2,613	3,420	2,814	2,276
84	2,688	3,520	2,896	2,341
85	2,785	3,647	3,001	2,426
86	2,865	3,751	3,088	2,496
87	2,946	3,856	3,176	2,567
88	3,029	3,966	3,266	2,640
89	3,114	4,075	3,354	2,714
90	3,199	4,187	3,448	2,786
91	3,286	4,302	3,541	2,863
92	3,373	4,418	3,636	2,939
93	3,464	4,535	3,733	3,020
94	3,556	4,655	3,832	3,099
95	3,650	4,776	3,932	3,180
96	3,743	4,901	4,034	3,262
97	3,839	5,026	4,137	3,344
98	3,935	5,154	4,240	3,430
99+	4,034	5,281	4,348	3,515

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 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 3/1/2020

Attained Age	Preferred Plan A	Plan F	Plan G	Plan N	Attained Age	Standard Plan A	Plan F	Plan G	Plan N
Under 65	2,844	3,723	3,065	2,479	Under 65	3,160	4,137	3,406	2,754
65	1,145	1,498	1,233	943	65	1,272	1,664	1,370	1,048
66	1,145	1,498	1,233	943	66	1,272	1,664	1,370	1,048
67	1,145	1,498	1,233	943	67	1,272	1,664	1,370	1,048
68	1,157	1,514	1,247	977	68	1,286	1,682	1,386	1,086
69	1,183	1,549	1,275	1,017	69	1,314	1,721	1,417	1,130
70	1,215	1,590	1,309	1,056	70	1,350	1,767	1,454	1,173
71	1,251	1,638	1,348	1,093	71	1,390	1,820	1,498	1,214
72	1,290	1,689	1,390	1,130	72	1,433	1,877	1,544	1,256
73	1,332	1,744	1,435	1,168	73	1,480	1,938	1,594	1,298
74	1,379	1,805	1,486	1,208	74	1,532	2,006	1,651	1,342
75	1,427	1,868	1,538	1,247	75	1,586	2,076	1,709	1,386
76	1,477	1,934	1,592	1,287	76	1,641	2,149	1,769	1,430
77	1,529	2,002	1,648	1,330	77	1,699	2,224	1,831	1,478
78	1,581	2,070	1,704	1,374	78	1,757	2,300	1,893	1,527
79	1,631	2,134	1,757	1,418	79	1,812	2,371	1,952	1,576
80	1,682	2,202	1,812	1,466	80	1,869	2,447	2,013	1,629
81	1,735	2,271	1,869	1,512	81	1,928	2,523	2,077	1,680
82	1,786	2,338	1,925	1,557	82	1,984	2,598	2,139	1,730
83	1,842	2,411	1,984	1,605	83	2,047	2,679	2,204	1,783
84	1,895	2,481	2,042	1,651	84	2,106	2,757	2,269	1,834
85	1,964	2,571	2,116	1,711	85	2,182	2,857	2,351	1,901
86	2,020	2,644	2,177	1,760	86	2,244	2,938	2,419	1,956
87	2,077	2,719	2,239	1,810	87	2,308	3,021	2,488	2,011
88	2,136	2,796	2,302	1,861	88	2,373	3,107	2,558	2,068
89	2,195	2,873	2,365	1,913	89	2,439	3,192	2,628	2,126
90	2,255	2,952	2,431	1,965	90	2,506	3,280	2,701	2,183
91	2,317	3,033	2,497	2,019	91	2,574	3,370	2,774	2,243
92	2,379	3,115	2,564	2,073	92	2,643	3,461	2,849	2,303
93	2,443	3,198	2,632	2,129	93	2,714	3,553	2,924	2,366
94	2,507	3,282	2,702	2,185	94	2,786	3,647	3,002	2,428
95	2,573	3,368	2,772	2,242	95	2,859	3,742	3,080	2,491
96	2,639	3,455	2,844	2,300	96	2,932	3,839	3,160	2,556
97	2,707	3,543	2,917	2,358	97	3,008	3,937	3,241	2,620
98	2,775	3,633	2,990	2,418	98	3,083	4,037	3,322	2,687
99+	2,844	3,723	3,065	2,479	99+	3,160	4,137	3,406	2,754

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 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 3/1/2020

Attained Age	Preferred				Attained Age	Standard			
	Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
Under 65	3,271	4,281	3,525	2,851	Under 65	3,634	4,758	3,917	3,167
65	1,317	1,723	1,418	1,084	65	1,463	1,914	1,576	1,205
66	1,317	1,723	1,418	1,084	66	1,463	1,914	1,576	1,205
67	1,317	1,723	1,418	1,084	67	1,463	1,914	1,576	1,205
68	1,331	1,741	1,434	1,124	68	1,479	1,934	1,594	1,249
69	1,360	1,781	1,466	1,170	69	1,511	1,979	1,630	1,300
70	1,397	1,829	1,505	1,214	70	1,553	2,032	1,672	1,349
71	1,439	1,884	1,550	1,257	71	1,599	2,093	1,723	1,396
72	1,484	1,942	1,599	1,300	72	1,648	2,159	1,776	1,444
73	1,532	2,006	1,650	1,343	73	1,702	2,229	1,833	1,493
74	1,586	2,076	1,709	1,389	74	1,762	2,307	1,899	1,543
75	1,641	2,148	1,769	1,434	75	1,824	2,387	1,965	1,594
76	1,699	2,224	1,831	1,480	76	1,887	2,471	2,034	1,645
77	1,758	2,302	1,895	1,530	77	1,954	2,558	2,106	1,700
78	1,818	2,381	1,960	1,580	78	2,021	2,645	2,177	1,756
79	1,876	2,454	2,021	1,631	79	2,084	2,727	2,245	1,812
80	1,934	2,532	2,084	1,686	80	2,149	2,814	2,315	1,873
81	1,995	2,612	2,149	1,739	81	2,217	2,901	2,389	1,932
82	2,054	2,689	2,214	1,791	82	2,282	2,988	2,460	1,990
83	2,118	2,773	2,282	1,846	83	2,354	3,081	2,535	2,050
84	2,179	2,853	2,348	1,899	84	2,422	3,171	2,609	2,109
85	2,259	2,957	2,433	1,968	85	2,509	3,286	2,704	2,186
86	2,323	3,041	2,504	2,024	86	2,581	3,379	2,782	2,249
87	2,389	3,127	2,575	2,082	87	2,654	3,474	2,861	2,313
88	2,456	3,215	2,647	2,140	88	2,729	3,573	2,942	2,378
89	2,524	3,304	2,720	2,200	89	2,805	3,671	3,022	2,445
90	2,593	3,395	2,796	2,260	90	2,882	3,772	3,106	2,510
91	2,665	3,488	2,872	2,322	91	2,960	3,876	3,190	2,579
92	2,736	3,582	2,949	2,384	92	3,039	3,980	3,276	2,648
93	2,809	3,678	3,027	2,448	93	3,121	4,086	3,363	2,721
94	2,883	3,774	3,107	2,513	94	3,204	4,194	3,452	2,792
95	2,959	3,873	3,188	2,578	95	3,288	4,303	3,542	2,865
96	3,035	3,973	3,271	2,645	96	3,372	4,415	3,634	2,939
97	3,113	4,074	3,355	2,712	97	3,459	4,528	3,727	3,013
98	3,191	4,178	3,439	2,781	98	3,545	4,643	3,820	3,090
99+	3,271	4,281	3,525	2,851	99+	3,634	4,758	3,917	3,167

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 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

In order to be eligible for the Household discount under an Accendo 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 us. The Medicare eligible adult must be (a) your spouse or your civil union partner; 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 14 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 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 $1,408	$0	$1,408 (Part A Deductible)
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	$0	Up to $176 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 $198 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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare Approved amounts*	$0	$0	$198 (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 $1,408	$1,408 (Part A Deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 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 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 $198 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 $198 of Medicare-Approved amounts*	$0	$198 (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 $198 of Medicare-Approved amounts*	$0	$198 (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 $198 of Medicare Approved amounts*	$0	$198 (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 $1,408	$1,408 (Part A Deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 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 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 $198 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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare Approved amounts*	$0	$0	$198 (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 $1,408	$1,408 (Part A Deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
*While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 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 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 $198 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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare Approved amounts*	$0	$0	$198 (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