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

Oregon

Benefit plans: A, F, G, N

Rates effective: (05/2022 C)

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(05/2022 C)

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: 970-972
Female rates

Rates effective 5/1/2022

ATTAINED AGE	PREFERRED			
	Plan A	Plan F	Plan G	Plan N
64	1,794	2,567	2,209	1,518
65	1,794	2,567	2,209	1,518
66	1,794	2,567	2,209	1,518
67	1,794	2,567	2,209	1,518
68	1,824	2,609	2,245	1,581
69	1,861	2,662	2,290	1,642
70	1,906	2,728	2,348	1,700
71	1,967	2,813	2,422	1,764
72	2,027	2,902	2,498	1,824
73	2,094	2,995	2,579	1,885
74	2,168	3,101	2,669	1,949
75	2,243	3,210	2,763	2,012
76	2,322	3,322	2,859	2,075
77	2,403	3,439	2,960	2,145
78	2,482	3,551	3,057	2,214
79	2,559	3,662	3,152	2,285
80	2,640	3,777	3,251	2,361
81	2,723	3,896	3,354	2,436
82	2,808	4,017	3,459	2,511
83	2,898	4,147	3,570	2,593
84	2,992	4,280	3,684	2,677
85	3,083	4,411	3,796	2,758
86	3,171	4,537	3,905	2,837
87	3,261	4,666	4,016	2,917
88	3,353	4,796	4,129	2,999
89	3,445	4,930	4,243	3,081
90	3,540	5,065	4,361	3,168
91	3,636	5,204	4,480	3,254
92	3,734	5,344	4,600	3,341
93	3,834	5,487	4,722	3,430
94	3,935	5,630	4,848	3,521
95	4,038	5,777	4,974	3,613
96	4,143	5,926	5,102	3,706
97	4,249	6,078	5,233	3,801
98	4,355	6,233	5,365	3,897
99+	4,464	6,388	5,499	3,994

ATTAINED AGE	STANDARD			
	Plan A	Plan F	Plan G	Plan N
64	1,994	2,851	2,456	1,686
65	1,994	2,851	2,456	1,686
66	1,994	2,851	2,456	1,686
67	1,994	2,851	2,456	1,686
68	2,025	2,898	2,495	1,756
69	2,067	2,957	2,545	1,824
70	2,119	3,031	2,608	1,889
71	2,185	3,126	2,691	1,960
72	2,253	3,223	2,775	2,025
73	2,326	3,328	2,866	2,095
74	2,409	3,445	2,966	2,166
75	2,493	3,566	3,069	2,236
76	2,580	3,692	3,177	2,306
77	2,671	3,820	3,290	2,384
78	2,759	3,945	3,398	2,460
79	2,844	4,069	3,503	2,539
80	2,932	4,197	3,613	2,624
81	3,025	4,329	3,727	2,706
82	3,120	4,464	3,843	2,791
83	3,221	4,607	3,967	2,882
84	3,325	4,757	4,094	2,974
85	3,426	4,902	4,219	3,064
86	3,523	5,041	4,340	3,152
87	3,624	5,185	4,461	3,242
88	3,726	5,329	4,589	3,332
89	3,828	5,477	4,715	3,425
90	3,933	5,628	4,845	3,519
91	4,041	5,782	4,977	3,616
92	4,150	5,938	5,111	3,713
93	4,260	6,096	5,246	3,811
94	4,372	6,256	5,387	3,912
95	4,488	6,420	5,526	4,014
96	4,603	6,586	5,670	4,118
97	4,720	6,754	5,814	4,223
98	4,839	6,925	5,961	4,331
99+	4,961	7,098	6,109	4,437

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**

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: 970-972

Male rates

Rates effective 5/1/2022

ATTAINED AGE	PREFERRED			
	Plan A	Plan F	Plan G	Plan N
64	2,063	2,952	2,541	1,746
65	2,063	2,952	2,541	1,746
66	2,063	2,952	2,541	1,746
67	2,063	2,952	2,541	1,746
68	2,097	3,001	2,582	1,818
69	2,140	3,062	2,633	1,887
70	2,193	3,138	2,700	1,955
71	2,262	3,235	2,785	2,028
72	2,332	3,336	2,873	2,097
73	2,408	3,444	2,966	2,168
74	2,494	3,565	3,071	2,241
75	2,580	3,692	3,177	2,314
76	2,669	3,820	3,289	2,387
77	2,764	3,955	3,405	2,468
78	2,855	4,083	3,515	2,546
79	2,944	4,212	3,625	2,627
80	3,036	4,344	3,739	2,715
81	3,132	4,481	3,856	2,802
82	3,229	4,619	3,977	2,889
83	3,333	4,769	4,106	2,983
84	3,441	4,924	4,237	3,078
85	3,546	5,073	4,367	3,171
86	3,646	5,217	4,492	3,262
87	3,751	5,365	4,618	3,355
88	3,855	5,515	4,749	3,449
89	3,962	5,670	4,880	3,545
90	4,071	5,826	5,015	3,642
91	4,182	5,984	5,152	3,742
92	4,295	6,145	5,290	3,842
93	4,409	6,310	5,430	3,944
94	4,526	6,475	5,575	4,048
95	4,644	6,645	5,720	4,155
96	4,764	6,816	5,869	4,262
97	4,886	6,990	6,018	4,371
98	5,009	7,168	6,170	4,482
99+	5,133	7,347	6,324	4,593

ATTAINED AGE	STANDARD			
	Plan A	Plan F	Plan G	Plan N
64	2,292	3,280	2,823	1,939
65	2,292	3,280	2,823	1,939
66	2,292	3,280	2,823	1,939
67	2,292	3,280	2,823	1,939
68	2,329	3,333	2,869	2,020
69	2,377	3,401	2,927	2,097
70	2,436	3,486	2,999	2,172
71	2,514	3,595	3,096	2,254
72	2,591	3,707	3,192	2,329
73	2,675	3,827	3,295	2,409
74	2,771	3,962	3,411	2,491
75	2,867	4,103	3,529	2,571
76	2,967	4,244	3,655	2,652
77	3,072	4,393	3,783	2,740
78	3,173	4,537	3,907	2,830
79	3,270	4,679	4,029	2,919
80	3,372	4,827	4,155	3,018
81	3,478	4,978	4,286	3,113
82	3,588	5,133	4,419	3,210
83	3,704	5,300	4,562	3,315
84	3,823	5,471	4,709	3,419
85	3,939	5,637	4,853	3,523
86	4,052	5,798	4,991	3,625
87	4,167	5,962	5,131	3,728
88	4,284	6,129	5,277	3,831
89	4,404	6,299	5,423	3,938
90	4,522	6,472	5,572	4,046
91	4,647	6,650	5,724	4,157
92	4,772	6,828	5,877	4,270
93	4,898	7,011	6,033	4,382
94	5,027	7,194	6,196	4,498
95	5,161	7,383	6,355	4,616
96	5,293	7,573	6,520	4,736
97	5,428	7,767	6,687	4,856
98	5,566	7,964	6,856	4,980
99+	5,704	8,162	7,026	5,102

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**

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

Female rates

Rates effective 5/1/2022

ATTAINED AGE	PREFERRED			
	Plan A	Plan F	Plan G	Plan N
64	1,646	2,355	2,027	1,393
65	1,646	2,355	2,027	1,393
66	1,646	2,355	2,027	1,393
67	1,646	2,355	2,027	1,393
68	1,673	2,394	2,060	1,450
69	1,707	2,442	2,101	1,506
70	1,749	2,503	2,154	1,560
71	1,805	2,581	2,222	1,618
72	1,860	2,662	2,292	1,673
73	1,921	2,748	2,366	1,729
74	1,989	2,845	2,449	1,788
75	2,058	2,945	2,535	1,846
76	2,130	3,048	2,623	1,904
77	2,205	3,155	2,716	1,968
78	2,277	3,258	2,805	2,031
79	2,348	3,360	2,892	2,096
80	2,422	3,465	2,983	2,166
81	2,498	3,574	3,077	2,235
82	2,576	3,685	3,173	2,304
83	2,659	3,805	3,275	2,379
84	2,745	3,927	3,380	2,456
85	2,828	4,047	3,483	2,530
86	2,909	4,162	3,583	2,603
87	2,992	4,281	3,684	2,676
88	3,076	4,400	3,788	2,751
89	3,161	4,523	3,893	2,827
90	3,248	4,647	4,001	2,906
91	3,336	4,774	4,110	2,985
92	3,426	4,903	4,220	3,065
93	3,517	5,034	4,332	3,147
94	3,610	5,165	4,448	3,230
95	3,705	5,300	4,563	3,315
96	3,801	5,437	4,681	3,400
97	3,898	5,576	4,801	3,487
98	3,995	5,718	4,922	3,575
99+	4,095	5,861	5,045	3,664

ATTAINED AGE	STANDARD			
	Plan A	Plan F	Plan G	Plan N
64	1,829	2,616	2,253	1,547
65	1,829	2,616	2,253	1,547
66	1,829	2,616	2,253	1,547
67	1,829	2,616	2,253	1,547
68	1,858	2,659	2,289	1,611
69	1,896	2,713	2,335	1,673
70	1,944	2,781	2,393	1,733
71	2,005	2,868	2,469	1,798
72	2,067	2,957	2,546	1,858
73	2,134	3,053	2,629	1,922
74	2,210	3,161	2,721	1,987
75	2,287	3,272	2,816	2,051
76	2,367	3,387	2,915	2,116
77	2,450	3,505	3,018	2,187
78	2,531	3,619	3,117	2,257
79	2,609	3,733	3,214	2,329
80	2,690	3,850	3,315	2,407
81	2,775	3,972	3,419	2,483
82	2,862	4,095	3,526	2,561
83	2,955	4,227	3,639	2,644
84	3,050	4,364	3,756	2,728
85	3,143	4,497	3,871	2,811
86	3,232	4,625	3,982	2,892
87	3,325	4,757	4,093	2,974
88	3,418	4,889	4,210	3,057
89	3,512	5,025	4,326	3,142
90	3,608	5,163	4,445	3,228
91	3,707	5,305	4,566	3,317
92	3,807	5,448	4,689	3,406
93	3,908	5,593	4,813	3,496
94	4,011	5,739	4,942	3,589
95	4,117	5,890	5,070	3,683
96	4,223	6,042	5,202	3,778
97	4,330	6,196	5,334	3,874
98	4,439	6,353	5,469	3,973
99+	4,551	6,512	5,605	4,071

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**

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 5/1/2022

ATTAINED AGE	PREFERRED			
	Plan A	Plan F	Plan G	Plan N
64	1,893	2,708	2,331	1,602
65	1,893	2,708	2,331	1,602
66	1,893	2,708	2,331	1,602
67	1,893	2,708	2,331	1,602
68	1,924	2,753	2,369	1,668
69	1,963	2,809	2,416	1,731
70	2,012	2,879	2,477	1,794
71	2,075	2,968	2,555	1,861
72	2,139	3,061	2,636	1,924
73	2,209	3,160	2,721	1,989
74	2,288	3,271	2,817	2,056
75	2,367	3,387	2,915	2,123
76	2,449	3,505	3,017	2,190
77	2,536	3,628	3,124	2,264
78	2,619	3,746	3,225	2,336
79	2,701	3,864	3,326	2,410
80	2,785	3,985	3,430	2,491
81	2,873	4,111	3,538	2,571
82	2,962	4,238	3,649	2,650
83	3,058	4,375	3,767	2,737
84	3,157	4,517	3,887	2,824
85	3,253	4,654	4,006	2,909
86	3,345	4,786	4,121	2,993
87	3,441	4,922	4,237	3,078
88	3,537	5,060	4,357	3,164
89	3,635	5,202	4,477	3,252
90	3,735	5,345	4,601	3,341
91	3,837	5,490	4,727	3,433
92	3,940	5,638	4,853	3,525
93	4,045	5,789	4,982	3,618
94	4,152	5,940	5,115	3,714
95	4,261	6,096	5,248	3,812
96	4,371	6,253	5,384	3,910
97	4,483	6,413	5,521	4,010
98	4,595	6,576	5,661	4,112
99+	4,709	6,740	5,802	4,214

ATTAINED AGE	STANDARD			
	Plan A	Plan F	Plan G	Plan N
64	2,103	3,009	2,590	1,779
65	2,103	3,009	2,590	1,779
66	2,103	3,009	2,590	1,779
67	2,103	3,009	2,590	1,779
68	2,137	3,058	2,632	1,853
69	2,181	3,120	2,685	1,924
70	2,235	3,198	2,751	1,993
71	2,306	3,298	2,840	2,068
72	2,377	3,401	2,928	2,137
73	2,454	3,511	3,023	2,210
74	2,542	3,635	3,129	2,285
75	2,630	3,764	3,238	2,359
76	2,722	3,894	3,353	2,433
77	2,818	4,030	3,471	2,514
78	2,911	4,162	3,584	2,596
79	3,000	4,293	3,696	2,678
80	3,094	4,428	3,812	2,769
81	3,191	4,567	3,932	2,856
82	3,292	4,709	4,054	2,945
83	3,398	4,862	4,185	3,041
84	3,507	5,019	4,320	3,137
85	3,614	5,172	4,452	3,232
86	3,717	5,319	4,579	3,326
87	3,823	5,470	4,707	3,420
88	3,930	5,623	4,841	3,515
89	4,040	5,779	4,975	3,613
90	4,149	5,938	5,112	3,712
91	4,263	6,101	5,251	3,814
92	4,378	6,264	5,392	3,917
93	4,494	6,432	5,535	4,020
94	4,612	6,600	5,684	4,127
95	4,735	6,773	5,830	4,235
96	4,856	6,948	5,982	4,345
97	4,980	7,126	6,135	4,455
98	5,106	7,306	6,290	4,569
99+	5,233	7,488	6,446	4,681

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**

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 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 $1,600	$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