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

Nevada

Benefit plans: A, F, G & N

Rates effective: (05/2022 A)

ACCMS05945NV
(05/2022 A)

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: 889 - 891

Female Rates

Rates Effective 5/1/2022

Attained	Preferred			
Age	Plan A	Plan F	Plan G	Plan N
65	1,529	1,868	1,722	1,161
66	1,529	1,868	1,722	1,161
67	1,529	1,868	1,722	1,161
68	1,555	1,900	1,750	1,210
69	1,587	1,938	1,784	1,256
70	1,625	1,986	1,830	1,301
71	1,676	2,048	1,887	1,349
72	1,730	2,112	1,945	1,395
73	1,785	2,182	2,009	1,442
74	1,849	2,258	2,080	1,491
75	1,914	2,337	2,152	1,540
76	1,980	2,418	2,228	1,589
77	2,050	2,505	2,307	1,642
78	2,117	2,586	2,381	1,695
79	2,183	2,667	2,456	1,749
80	2,252	2,750	2,533	1,807
81	2,322	2,837	2,613	1,863
82	2,395	2,925	2,695	1,922
83	2,472	3,020	2,782	1,985
84	2,552	3,117	2,871	2,048
85	2,629	3,212	2,959	2,110
86	2,704	3,304	3,043	2,171
87	2,781	3,398	3,129	2,232
88	2,859	3,492	3,217	2,295
89	2,938	3,590	3,306	2,359
90	3,019	3,687	3,398	2,422
91	3,102	3,789	3,489	2,489
92	3,185	3,890	3,585	2,556
93	3,269	3,995	3,680	2,624
94	3,357	4,100	3,777	2,694
95	3,443	4,206	3,876	2,765
96	3,532	4,315	3,975	2,835
97	3,623	4,425	4,077	2,907
98	3,714	4,537	4,181	2,981
99+	3,807	4,650	4,285	3,055

Attained	Standard			
Age	Plan A	Plan F	Plan G	Plan N
65	1,700	2,077	1,914	1,291
66	1,700	2,077	1,914	1,291
67	1,700	2,077	1,914	1,291
68	1,728	2,111	1,944	1,344
69	1,763	2,154	1,982	1,395
70	1,806	2,205	2,034	1,446
71	1,862	2,276	2,096	1,499
72	1,922	2,347	2,161	1,550
73	1,983	2,424	2,232	1,602
74	2,054	2,510	2,311	1,658
75	2,125	2,596	2,392	1,711
76	2,200	2,687	2,476	1,766
77	2,278	2,782	2,563	1,824
78	2,351	2,872	2,646	1,882
79	2,425	2,962	2,729	1,943
80	2,501	3,055	2,814	2,007
81	2,580	3,151	2,903	2,070
82	2,661	3,250	2,994	2,136
83	2,746	3,357	3,091	2,204
84	2,835	3,462	3,190	2,276
85	2,921	3,568	3,289	2,345
86	3,005	3,671	3,381	2,412
87	3,090	3,775	3,478	2,481
88	3,177	3,880	3,574	2,550
89	3,264	3,990	3,673	2,621
90	3,354	4,096	3,775	2,692
91	3,446	4,210	3,878	2,767
92	3,538	4,323	3,982	2,840
93	3,633	4,439	4,089	2,916
94	3,729	4,554	4,196	2,993
95	3,825	4,673	4,306	3,072
96	3,925	4,794	4,417	3,150
97	4,026	4,917	4,530	3,230
98	4,127	5,041	4,645	3,312
99+	4,229	5,168	4,761	3,396

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 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 Period, use Preferred rates.

Accendo Insurance Company

Annual Premiums

For Use in ZIP Codes: 889 - 891

Male Rates

Rates Effective 5/1/2022

Attained Age	Preferred Plan A	Preferred Plan F	Preferred Plan G	Preferred Plan N	Attained Age	Standard Plan A	Standard Plan F	Standard Plan G	Standard Plan N
65	1,758	2,149	1,980	1,336	65	1,955	2,388	2,200	1,484
66	1,758	2,149	1,980	1,336	66	1,955	2,388	2,200	1,484
67	1,758	2,149	1,980	1,336	67	1,955	2,388	2,200	1,484
68	1,788	2,185	2,012	1,391	68	1,987	2,428	2,236	1,545
69	1,824	2,228	2,052	1,444	69	2,027	2,476	2,279	1,604
70	1,868	2,284	2,105	1,497	70	2,076	2,536	2,338	1,663
71	1,928	2,355	2,170	1,552	71	2,142	2,618	2,411	1,725
72	1,989	2,430	2,237	1,604	72	2,211	2,700	2,485	1,782
73	2,053	2,509	2,310	1,658	73	2,281	2,787	2,567	1,842
74	2,125	2,597	2,393	1,715	74	2,363	2,886	2,659	1,906
75	2,200	2,687	2,475	1,771	75	2,445	2,986	2,751	1,968
76	2,277	2,781	2,562	1,826	76	2,530	3,090	2,848	2,030
77	2,358	2,880	2,654	1,888	77	2,620	3,199	2,948	2,098
78	2,434	2,973	2,739	1,948	78	2,704	3,303	3,043	2,164
79	2,510	3,067	2,824	2,011	79	2,789	3,406	3,138	2,235
80	2,590	3,162	2,914	2,078	80	2,877	3,514	3,237	2,308
81	2,670	3,263	3,005	2,143	81	2,967	3,624	3,339	2,380
82	2,754	3,363	3,099	2,211	82	3,061	3,737	3,443	2,456
83	2,843	3,473	3,199	2,283	83	3,158	3,860	3,555	2,535
84	2,934	3,585	3,302	2,355	84	3,261	3,982	3,669	2,618
85	3,023	3,694	3,403	2,427	85	3,360	4,104	3,781	2,697
86	3,110	3,799	3,499	2,496	86	3,455	4,222	3,889	2,773
87	3,198	3,906	3,599	2,567	87	3,554	4,341	3,999	2,853
88	3,289	4,015	3,700	2,638	88	3,654	4,461	4,110	2,932
89	3,378	4,128	3,803	2,712	89	3,753	4,588	4,224	3,013
90	3,472	4,240	3,906	2,786	90	3,858	4,711	4,341	3,095
91	3,566	4,358	4,013	2,863	91	3,964	4,842	4,459	3,182
92	3,662	4,474	4,121	2,940	92	4,069	4,971	4,580	3,266
93	3,759	4,594	4,231	3,018	93	4,179	5,105	4,702	3,352
94	3,860	4,714	4,343	3,097	94	4,289	5,237	4,825	3,442
95	3,959	4,836	4,457	3,180	95	4,400	5,374	4,953	3,532
96	4,062	4,963	4,572	3,261	96	4,513	5,514	5,080	3,623
97	4,167	5,089	4,688	3,344	97	4,630	5,654	5,209	3,715
98	4,271	5,219	4,808	3,428	98	4,747	5,797	5,342	3,810
99+	4,377	5,348	4,928	3,514	99+	4,863	5,943	5,476	3,904

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 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 Period, 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	Preferred Plan F	Preferred Plan G	Preferred Plan N	Attained Age	Standard Plan A	Standard Plan F	Standard Plan G	Standard Plan N
65	1,416	1,730	1,594	1,075	65	1,574	1,923	1,772	1,195
66	1,416	1,730	1,594	1,075	66	1,574	1,923	1,772	1,195
67	1,416	1,730	1,594	1,075	67	1,574	1,923	1,772	1,195
68	1,440	1,759	1,620	1,120	68	1,600	1,955	1,800	1,244
69	1,469	1,794	1,652	1,163	69	1,632	1,994	1,835	1,292
70	1,505	1,839	1,694	1,205	70	1,672	2,042	1,883	1,339
71	1,552	1,896	1,747	1,249	71	1,724	2,107	1,941	1,388
72	1,602	1,956	1,801	1,292	72	1,780	2,173	2,001	1,435
73	1,653	2,020	1,860	1,335	73	1,836	2,244	2,067	1,483
74	1,712	2,091	1,926	1,381	74	1,902	2,324	2,140	1,535
75	1,772	2,164	1,993	1,426	75	1,968	2,404	2,215	1,584
76	1,833	2,239	2,063	1,471	76	2,037	2,488	2,293	1,635
77	1,898	2,319	2,136	1,520	77	2,109	2,576	2,373	1,689
78	1,960	2,394	2,205	1,569	78	2,177	2,659	2,450	1,743
79	2,021	2,469	2,274	1,619	79	2,245	2,743	2,527	1,799
80	2,085	2,546	2,345	1,673	80	2,316	2,829	2,606	1,858
81	2,150	2,627	2,419	1,725	81	2,389	2,918	2,688	1,917
82	2,218	2,708	2,495	1,780	82	2,464	3,009	2,772	1,978
83	2,289	2,796	2,576	1,838	83	2,543	3,108	2,862	2,041
84	2,363	2,886	2,658	1,896	84	2,625	3,206	2,954	2,107
85	2,434	2,974	2,740	1,954	85	2,705	3,304	3,045	2,171
86	2,504	3,059	2,818	2,010	86	2,782	3,399	3,131	2,233
87	2,575	3,146	2,897	2,067	87	2,861	3,495	3,220	2,297
88	2,647	3,233	2,979	2,125	88	2,942	3,593	3,309	2,361
89	2,720	3,324	3,061	2,184	89	3,022	3,694	3,401	2,427
90	2,795	3,414	3,146	2,243	90	3,106	3,793	3,495	2,493
91	2,872	3,508	3,231	2,305	91	3,191	3,898	3,591	2,562
92	2,949	3,602	3,319	2,367	92	3,276	4,003	3,687	2,630
93	3,027	3,699	3,407	2,430	93	3,364	4,110	3,786	2,700
94	3,108	3,796	3,497	2,494	94	3,453	4,217	3,885	2,771
95	3,188	3,894	3,589	2,560	95	3,542	4,327	3,987	2,844
96	3,270	3,995	3,681	2,625	96	3,634	4,439	4,090	2,917
97	3,355	4,097	3,775	2,692	97	3,728	4,553	4,194	2,991
98	3,439	4,201	3,871	2,760	98	3,821	4,668	4,301	3,067
99+	3,525	4,306	3,968	2,829	99+	3,916	4,785	4,408	3,144

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 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 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 Plan A	Preferred Plan F	Preferred Plan G	Preferred Plan N	Attained Age	Standard Plan A	Standard Plan F	Standard Plan G	Standard Plan N
65	1,628	1,990	1,833	1,237	65	1,810	2,211	2,037	1,374
66	1,628	1,990	1,833	1,237	66	1,810	2,211	2,037	1,374
67	1,628	1,990	1,833	1,237	67	1,810	2,211	2,037	1,374
68	1,656	2,023	1,863	1,288	68	1,840	2,248	2,070	1,431
69	1,689	2,063	1,900	1,337	69	1,877	2,293	2,110	1,485
70	1,730	2,115	1,949	1,386	70	1,922	2,348	2,165	1,540
71	1,785	2,181	2,009	1,437	71	1,983	2,424	2,232	1,597
72	1,842	2,250	2,071	1,485	72	2,047	2,500	2,301	1,650
73	1,901	2,323	2,139	1,535	73	2,112	2,581	2,377	1,706
74	1,968	2,405	2,216	1,588	74	2,188	2,672	2,462	1,765
75	2,037	2,488	2,292	1,640	75	2,264	2,765	2,547	1,822
76	2,108	2,575	2,372	1,691	76	2,343	2,861	2,637	1,880
77	2,183	2,667	2,457	1,748	77	2,426	2,962	2,730	1,943
78	2,254	2,753	2,536	1,804	78	2,504	3,058	2,818	2,004
79	2,324	2,840	2,615	1,862	79	2,582	3,154	2,906	2,069
80	2,398	2,928	2,698	1,924	80	2,664	3,254	2,997	2,137
81	2,472	3,021	2,782	1,984	81	2,747	3,356	3,092	2,204
82	2,550	3,114	2,869	2,047	82	2,834	3,460	3,188	2,274
83	2,632	3,216	2,962	2,114	83	2,924	3,574	3,292	2,347
84	2,717	3,319	3,057	2,181	84	3,019	3,687	3,397	2,424
85	2,799	3,420	3,151	2,247	85	3,111	3,800	3,501	2,497
86	2,880	3,518	3,240	2,311	86	3,199	3,909	3,601	2,568
87	2,961	3,617	3,332	2,377	87	3,291	4,019	3,703	2,642
88	3,045	3,718	3,426	2,443	88	3,383	4,131	3,806	2,715
89	3,128	3,822	3,521	2,511	89	3,475	4,248	3,911	2,790
90	3,215	3,926	3,617	2,580	90	3,572	4,362	4,019	2,866
91	3,302	4,035	3,716	2,651	91	3,670	4,483	4,129	2,946
92	3,391	4,143	3,816	2,722	92	3,768	4,603	4,241	3,024
93	3,481	4,254	3,918	2,794	93	3,869	4,727	4,354	3,104
94	3,574	4,365	4,021	2,868	94	3,971	4,849	4,468	3,187
95	3,666	4,478	4,127	2,944	95	4,074	4,976	4,586	3,270
96	3,761	4,595	4,233	3,019	96	4,179	5,106	4,704	3,355
97	3,858	4,712	4,341	3,096	97	4,287	5,235	4,823	3,440
98	3,955	4,832	4,452	3,174	98	4,395	5,368	4,946	3,528
99+	4,053	4,952	4,563	3,254	99+	4,503	5,503	5,070	3,615

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 the 14% Household discount:

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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 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 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 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