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

Arizona

Benefit plans: A, F, G, N

Rates effective: (03/2021 A)

ACCMS05311AZ
(03/2021 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 2021[2]					**$6,220[2]**	**$3,110[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,370 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: 850-853 and 857
Female Rates

Rates Effective 3/1/2021

Issue Age	Preferred				Issue Age	Standard			
	Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
65	1,409	1,770	1,550	1,170	65	1,565	1,967	1,721	1,300
66	1,419	1,783	1,561	1,184	66	1,577	1,982	1,735	1,315
67	1,441	1,810	1,585	1,208	67	1,601	2,012	1,761	1,342
68	1,468	1,846	1,615	1,238	68	1,632	2,051	1,794	1,376
69	1,503	1,889	1,652	1,272	69	1,670	2,098	1,836	1,413
70	1,537	1,930	1,691	1,303	70	1,708	2,145	1,878	1,446
71	1,571	1,973	1,727	1,332	71	1,744	2,193	1,919	1,480
72	1,604	2,017	1,766	1,363	72	1,783	2,241	1,962	1,513
73	1,638	2,059	1,803	1,390	73	1,820	2,288	2,003	1,543
74	1,675	2,105	1,843	1,420	74	1,862	2,338	2,047	1,578
75	1,712	2,152	1,884	1,451	75	1,902	2,390	2,093	1,612
76	1,753	2,201	1,927	1,485	76	1,947	2,446	2,142	1,649
77	1,797	2,258	1,977	1,524	77	1,996	2,509	2,197	1,693
78	1,844	2,317	2,028	1,563	78	2,049	2,576	2,253	1,737
79	1,891	2,376	2,080	1,603	79	2,102	2,640	2,311	1,782
80	1,943	2,443	2,137	1,649	80	2,159	2,714	2,376	1,832
81	1,997	2,509	2,196	1,694	81	2,219	2,788	2,441	1,881
82	2,049	2,576	2,253	1,739	82	2,276	2,861	2,504	1,931
83	2,106	2,647	2,315	1,787	83	2,339	2,940	2,572	1,985
84	2,159	2,715	2,376	1,832	84	2,400	3,017	2,640	2,036
85	2,232	2,806	2,455	1,894	85	2,480	3,116	2,727	2,105
86	2,289	2,878	2,518	1,942	86	2,543	3,197	2,797	2,158
87	2,349	2,951	2,583	1,993	87	2,609	3,278	2,870	2,214
88	2,408	3,026	2,649	2,043	88	2,676	3,363	2,943	2,269
89	2,469	3,102	2,715	2,095	89	2,744	3,447	3,017	2,327
90	2,531	3,180	2,783	2,147	90	2,812	3,533	3,091	2,385
91	2,592	3,257	2,851	2,200	91	2,881	3,619	3,168	2,445
92	2,654	3,335	2,920	2,252	92	2,950	3,706	3,244	2,503
93	2,717	3,414	2,989	2,305	93	3,019	3,793	3,320	2,562
94	2,777	3,491	3,056	2,357	94	3,087	3,878	3,395	2,618
95	2,837	3,565	3,120	2,407	95	3,152	3,961	3,466	2,675
96	2,892	3,634	3,181	2,454	96	3,213	4,037	3,534	2,726
97	2,940	3,694	3,233	2,494	97	3,267	4,105	3,593	2,771
98	2,978	3,741	3,275	2,526	98	3,309	4,157	3,640	2,807
99+	3,000	3,770	3,299	2,545	99+	3,333	4,189	3,666	2,829

Modal Factors: Semi-Annual: 0.520 Quarterly: 0.2650 Monthly: 0.0833

The one-time policy fee of $25 is not included in the rates provided above.

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: 850-853 and 857
Male Rates

Rates Effective 3/1/2021

Issue Age	Preferred				Issue Age	Standard			
	Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
65	1,621	2,036	1,782	1,345	65	1,801	2,263	1,981	1,494
66	1,632	2,051	1,795	1,360	66	1,814	2,279	1,995	1,512
67	1,657	2,082	1,824	1,389	67	1,841	2,314	2,026	1,542
68	1,688	2,123	1,857	1,424	68	1,877	2,359	2,063	1,582
69	1,729	2,172	1,901	1,463	69	1,921	2,412	2,111	1,624
70	1,767	2,220	1,945	1,498	70	1,964	2,467	2,159	1,664
71	1,806	2,269	1,986	1,533	71	2,007	2,521	2,207	1,701
72	1,845	2,318	2,031	1,566	72	2,051	2,578	2,256	1,740
73	1,884	2,367	2,073	1,598	73	2,093	2,631	2,304	1,776
74	1,927	2,421	2,120	1,633	74	2,142	2,688	2,354	1,815
75	1,969	2,474	2,167	1,669	75	2,188	2,749	2,407	1,854
76	2,015	2,531	2,217	1,708	76	2,239	2,813	2,463	1,897
77	2,067	2,596	2,274	1,753	77	2,296	2,885	2,527	1,947
78	2,121	2,665	2,333	1,799	78	2,357	2,962	2,591	1,998
79	2,175	2,732	2,393	1,844	79	2,417	3,037	2,657	2,050
80	2,236	2,809	2,458	1,897	80	2,484	3,121	2,732	2,107
81	2,297	2,885	2,526	1,948	81	2,553	3,206	2,807	2,165
82	2,357	2,962	2,591	1,999	82	2,617	3,291	2,880	2,221
83	2,422	3,043	2,662	2,055	83	2,691	3,381	2,958	2,282
84	2,484	3,122	2,732	2,107	84	2,761	3,469	3,037	2,341
85	2,567	3,226	2,823	2,178	85	2,853	3,584	3,136	2,421
86	2,632	3,309	2,896	2,235	86	2,924	3,677	3,218	2,482
87	2,701	3,393	2,971	2,291	87	3,001	3,770	3,301	2,545
88	2,770	3,480	3,045	2,350	88	3,077	3,867	3,384	2,609
89	2,839	3,568	3,122	2,409	89	3,156	3,963	3,469	2,676
90	2,910	3,657	3,200	2,469	90	3,234	4,064	3,554	2,744
91	2,981	3,746	3,279	2,530	91	3,314	4,162	3,643	2,811
92	3,052	3,836	3,358	2,590	92	3,392	4,262	3,730	2,879
93	3,125	3,926	3,437	2,651	93	3,473	4,362	3,818	2,946
94	3,195	4,014	3,515	2,710	94	3,550	4,460	3,905	3,012
95	3,263	4,099	3,588	2,768	95	3,624	4,555	3,986	3,076
96	3,326	4,179	3,658	2,822	96	3,695	4,643	4,065	3,135
97	3,381	4,249	3,718	2,868	97	3,756	4,721	4,132	3,186
98	3,425	4,302	3,767	2,905	98	3,805	4,781	4,186	3,227
99+	3,450	4,335	3,794	2,928	99+	3,832	4,817	4,215	3,253

Modal Factors: Semi-Annual: 0.520 Quarterly: 0.2650 Monthly: 0.0833

The one-time policy fee of $25 is not included in the rates provided above.

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 3/1/2021

Issue Age	Preferred				Issue Age	Standard			
	Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
65	1,293	1,624	1,422	1,073	65	1,436	1,805	1,579	1,193
66	1,302	1,636	1,432	1,086	66	1,447	1,818	1,592	1,206
67	1,322	1,661	1,454	1,108	67	1,469	1,846	1,616	1,231
68	1,347	1,694	1,482	1,136	68	1,497	1,882	1,646	1,262
69	1,379	1,733	1,516	1,167	69	1,532	1,925	1,684	1,296
70	1,410	1,771	1,551	1,195	70	1,567	1,968	1,723	1,327
71	1,441	1,810	1,584	1,222	71	1,600	2,012	1,761	1,358
72	1,472	1,850	1,620	1,250	72	1,636	2,056	1,800	1,388
73	1,503	1,889	1,654	1,275	73	1,670	2,099	1,838	1,416
74	1,537	1,931	1,691	1,303	74	1,708	2,145	1,878	1,448
75	1,571	1,974	1,728	1,331	75	1,745	2,193	1,920	1,479
76	1,608	2,019	1,768	1,362	76	1,786	2,244	1,965	1,513
77	1,649	2,072	1,814	1,398	77	1,831	2,302	2,016	1,553
78	1,692	2,126	1,861	1,434	78	1,880	2,363	2,067	1,594
79	1,735	2,180	1,908	1,471	79	1,928	2,422	2,120	1,635
80	1,783	2,241	1,961	1,513	80	1,981	2,490	2,180	1,681
81	1,832	2,302	2,015	1,554	81	2,036	2,558	2,239	1,726
82	1,880	2,363	2,067	1,595	82	2,088	2,625	2,297	1,772
83	1,932	2,428	2,124	1,639	83	2,146	2,697	2,360	1,821
84	1,981	2,491	2,180	1,681	84	2,202	2,768	2,422	1,868
85	2,048	2,574	2,252	1,738	85	2,275	2,859	2,502	1,931
86	2,100	2,640	2,310	1,782	86	2,333	2,933	2,566	1,980
87	2,155	2,707	2,370	1,828	87	2,394	3,007	2,633	2,031
88	2,209	2,776	2,430	1,874	88	2,455	3,085	2,700	2,082
89	2,265	2,846	2,491	1,922	89	2,517	3,162	2,768	2,135
90	2,322	2,917	2,553	1,970	90	2,580	3,241	2,836	2,188
91	2,378	2,988	2,616	2,018	91	2,643	3,320	2,906	2,243
92	2,435	3,060	2,679	2,066	92	2,706	3,400	2,976	2,296
93	2,493	3,132	2,742	2,115	93	2,770	3,480	3,046	2,350
94	2,548	3,203	2,804	2,162	94	2,832	3,558	3,115	2,402
95	2,603	3,271	2,862	2,208	95	2,892	3,634	3,180	2,454
96	2,653	3,334	2,918	2,251	96	2,948	3,704	3,242	2,501
97	2,697	3,389	2,966	2,288	97	2,997	3,766	3,296	2,542
98	2,732	3,432	3,005	2,317	98	3,036	3,814	3,339	2,575
99+	2,752	3,459	3,027	2,335	99+	3,058	3,843	3,363	2,595

Modal Factors: Semi-Annual: 0.520 Quarterly: 0.2650 Monthly: 0.0833

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To calculate a Household discount:

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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 3/1/2021

Issue Age	Preferred				Issue Age	Standard			
	Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
65	1,487	1,868	1,635	1,234	65	1,652	2,076	1,817	1,371
66	1,497	1,882	1,647	1,248	66	1,664	2,091	1,830	1,387
67	1,520	1,910	1,673	1,274	67	1,689	2,123	1,859	1,415
68	1,549	1,948	1,704	1,306	68	1,722	2,164	1,893	1,451
69	1,586	1,993	1,744	1,342	69	1,762	2,213	1,937	1,490
70	1,621	2,037	1,784	1,374	70	1,802	2,263	1,981	1,527
71	1,657	2,082	1,822	1,406	71	1,841	2,313	2,025	1,561
72	1,693	2,127	1,863	1,437	72	1,882	2,365	2,070	1,596
73	1,728	2,172	1,902	1,466	73	1,920	2,414	2,114	1,629
74	1,768	2,221	1,945	1,498	74	1,965	2,466	2,160	1,665
75	1,806	2,270	1,988	1,531	75	2,007	2,522	2,208	1,701
76	1,849	2,322	2,034	1,567	76	2,054	2,581	2,260	1,740
77	1,896	2,382	2,086	1,608	77	2,106	2,647	2,318	1,786
78	1,946	2,445	2,140	1,650	78	2,162	2,717	2,377	1,833
79	1,995	2,506	2,195	1,692	79	2,217	2,786	2,438	1,881
80	2,051	2,577	2,255	1,740	80	2,279	2,863	2,506	1,933
81	2,107	2,647	2,317	1,787	81	2,342	2,941	2,575	1,986
82	2,162	2,717	2,377	1,834	82	2,401	3,019	2,642	2,038
83	2,222	2,792	2,442	1,885	83	2,469	3,102	2,714	2,094
84	2,279	2,864	2,506	1,933	84	2,533	3,183	2,786	2,148
85	2,355	2,960	2,590	1,998	85	2,617	3,288	2,877	2,221
86	2,415	3,036	2,657	2,050	86	2,683	3,373	2,952	2,277
87	2,478	3,113	2,726	2,102	87	2,753	3,459	3,028	2,335
88	2,541	3,193	2,794	2,156	88	2,823	3,548	3,105	2,394
89	2,605	3,273	2,864	2,210	89	2,895	3,636	3,183	2,455
90	2,670	3,355	2,936	2,265	90	2,967	3,728	3,261	2,517
91	2,735	3,437	3,008	2,321	91	3,040	3,818	3,342	2,579
92	2,800	3,519	3,081	2,376	92	3,112	3,910	3,422	2,641
93	2,867	3,602	3,153	2,432	93	3,186	4,002	3,503	2,703
94	2,931	3,683	3,225	2,486	94	3,257	4,092	3,583	2,763
95	2,994	3,761	3,292	2,539	95	3,325	4,179	3,657	2,822
96	3,051	3,834	3,356	2,589	96	3,390	4,260	3,729	2,876
97	3,102	3,898	3,411	2,631	97	3,446	4,331	3,791	2,923
98	3,142	3,947	3,456	2,665	98	3,491	4,386	3,840	2,961
99+	3,165	3,977	3,481	2,686	99+	3,516	4,419	3,867	2,984

Modal Factors: Semi-Annual: 0.520 Quarterly: 0.2650 Monthly: 0.0833

The one-time policy fee of $25 is not included in the rates provided above.

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 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 $1,484	$0	$1,484 (Part A Deductible)
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	$0	Up to $185.50 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 $203 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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $203 of Medicare-Approved amounts*	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$203 (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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $203 of Medicare-Approved amounts*	$0	$0	$203 (Unless Part B Deductible has been met)
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 $203 of Medicare-Approved amounts*	$0	$0	$203 (Unless Part B Deductible has been met)
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 $203 of Medicare Approved amounts*	$0	$0	$203 (Unless Part B Deductible has been met)
•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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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