



®

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

Michigan

Benefit plans: A, F, G & N

Rates effective: (03/2021 A)

ACCMS05319MI
(03/2021 A)

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ACCENDO INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE
BENEFIT PLANS AVAILABLE: A, F, G, N

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G ¹	K	L	M	N	C	F ¹
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
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: 480-485

Female Rates

Rates Effective: 3/1/2021

Attained Age	Preferred				Attained Age	Standard			
	Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
65	1,486	1,961	1,701	1,286	65	1,651	2,178	1,891	1,430
66	1,486	1,961	1,701	1,286	66	1,651	2,178	1,891	1,430
67	1,486	1,961	1,701	1,286	67	1,651	2,178	1,891	1,430
68	1,502	1,980	1,719	1,332	68	1,668	2,201	1,911	1,481
69	1,536	2,025	1,759	1,387	69	1,707	2,251	1,954	1,541
70	1,577	2,079	1,804	1,440	70	1,752	2,309	2,006	1,599
71	1,624	2,142	1,859	1,490	71	1,804	2,380	2,065	1,656
72	1,675	2,208	1,918	1,541	72	1,862	2,455	2,130	1,713
73	1,730	2,280	1,979	1,592	73	1,922	2,534	2,200	1,769
74	1,791	2,361	2,050	1,647	74	1,990	2,623	2,278	1,830
75	1,852	2,442	2,122	1,699	75	2,058	2,715	2,357	1,889
76	1,918	2,529	2,196	1,756	76	2,130	2,810	2,439	1,950
77	1,986	2,618	2,273	1,813	77	2,206	2,910	2,525	2,014
78	2,052	2,707	2,350	1,874	78	2,280	3,007	2,611	2,083
79	2,117	2,791	2,424	1,935	79	2,352	3,101	2,693	2,150
80	2,183	2,879	2,500	1,998	80	2,425	3,200	2,777	2,220
81	2,252	2,969	2,579	2,061	81	2,502	3,300	2,866	2,290
82	2,319	3,057	2,655	2,123	82	2,577	3,398	2,949	2,358
83	2,390	3,152	2,736	2,187	83	2,656	3,503	3,040	2,431
84	2,461	3,245	2,817	2,252	84	2,734	3,605	3,129	2,502
85	2,550	3,362	2,919	2,334	85	2,833	3,737	3,244	2,593
86	2,622	3,459	3,002	2,401	86	2,913	3,843	3,335	2,667
87	2,696	3,556	3,088	2,468	87	2,996	3,950	3,431	2,743
88	2,772	3,656	3,174	2,538	88	3,079	4,063	3,527	2,819
89	2,850	3,759	3,262	2,608	89	3,167	4,176	3,626	2,898
90	2,928	3,861	3,353	2,680	90	3,254	4,290	3,725	2,977
91	3,007	3,966	3,443	2,752	91	3,342	4,407	3,826	3,059
92	3,089	4,074	3,536	2,827	92	3,432	4,526	3,928	3,142
93	3,171	4,182	3,631	2,902	93	3,523	4,647	4,033	3,226
94	3,255	4,293	3,726	2,979	94	3,616	4,769	4,141	3,310
95	3,339	4,404	3,823	3,056	95	3,711	4,893	4,249	3,396
96	3,426	4,518	3,922	3,135	96	3,806	5,020	4,358	3,484
97	3,514	4,634	4,022	3,217	97	3,904	5,148	4,469	3,575
98	3,603	4,749	4,125	3,298	98	4,002	5,278	4,584	3,664
99+	3,692	4,869	4,227	3,379	99+	4,102	5,409	4,697	3,755

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: 480-485

Male Rates

Rates Effective: 3/1/2021

Attained Age	Preferred				Attained Age	Standard			
	Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
65	1,709	2,255	1,956	1,480	65	1,898	2,505	2,174	1,643
66	1,709	2,255	1,956	1,480	66	1,898	2,505	2,174	1,643
67	1,709	2,255	1,956	1,480	67	1,898	2,505	2,174	1,643
68	1,726	2,278	1,976	1,532	68	1,918	2,532	2,197	1,702
69	1,767	2,329	2,023	1,595	69	1,963	2,589	2,248	1,771
70	1,814	2,390	2,075	1,657	70	2,015	2,656	2,307	1,840
71	1,868	2,463	2,137	1,713	71	2,075	2,738	2,375	1,903
72	1,926	2,540	2,206	1,771	72	2,141	2,822	2,450	1,970
73	1,990	2,622	2,277	1,830	73	2,209	2,915	2,530	2,034
74	2,059	2,715	2,357	1,895	74	2,288	3,017	2,619	2,105
75	2,130	2,810	2,439	1,954	75	2,367	3,122	2,711	2,172
76	2,206	2,908	2,525	2,019	76	2,450	3,231	2,806	2,242
77	2,284	3,012	2,613	2,084	77	2,536	3,346	2,904	2,316
78	2,359	3,113	2,701	2,155	78	2,622	3,459	3,002	2,396
79	2,434	3,210	2,788	2,225	79	2,705	3,566	3,096	2,473
80	2,511	3,311	2,874	2,298	80	2,789	3,681	3,194	2,553
81	2,590	3,415	2,966	2,370	81	2,877	3,794	3,296	2,634
82	2,667	3,516	3,052	2,441	82	2,963	3,908	3,390	2,712
83	2,749	3,626	3,146	2,516	83	3,054	4,027	3,495	2,796
84	2,829	3,732	3,239	2,590	84	3,144	4,146	3,598	2,877
85	2,932	3,867	3,357	2,684	85	3,257	4,298	3,731	2,982
86	3,016	3,977	3,454	2,761	86	3,350	4,420	3,837	3,067
87	3,101	4,089	3,551	2,839	87	3,447	4,543	3,945	3,154
88	3,188	4,204	3,651	2,918	88	3,542	4,671	4,055	3,243
89	3,278	4,322	3,752	2,999	89	3,642	4,802	4,170	3,332
90	3,367	4,440	3,856	3,082	90	3,742	4,934	4,283	3,425
91	3,459	4,560	3,960	3,166	91	3,843	5,068	4,401	3,517
92	3,553	4,685	4,066	3,251	92	3,947	5,205	4,518	3,612
93	3,645	4,810	4,175	3,338	93	4,052	5,345	4,638	3,710
94	3,743	4,937	4,285	3,427	94	4,158	5,484	4,762	3,808
95	3,841	5,065	4,398	3,515	95	4,269	5,628	4,887	3,905
96	3,939	5,196	4,510	3,606	96	4,377	5,773	5,012	4,006
97	4,041	5,329	4,626	3,699	97	4,490	5,921	5,140	4,110
98	4,143	5,462	4,743	3,792	98	4,603	6,070	5,272	4,213
99+	4,246	5,600	4,862	3,887	99+	4,717	6,221	5,402	4,319

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: 486-489 and 492
 Female Rates

Rates Effective: 3/1/2021

Attained Age	Preferred				Attained Age	Standard			
	Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
65	1,267	1,671	1,450	1,096	65	1,407	1,856	1,612	1,219
66	1,267	1,671	1,450	1,096	66	1,407	1,856	1,612	1,219
67	1,267	1,671	1,450	1,096	67	1,407	1,856	1,612	1,219
68	1,280	1,688	1,465	1,136	68	1,422	1,876	1,629	1,263
69	1,309	1,726	1,500	1,182	69	1,455	1,919	1,666	1,314
70	1,345	1,772	1,538	1,227	70	1,493	1,969	1,710	1,363
71	1,384	1,826	1,585	1,270	71	1,538	2,029	1,761	1,411
72	1,428	1,882	1,635	1,314	72	1,587	2,092	1,816	1,460
73	1,475	1,944	1,687	1,357	73	1,638	2,160	1,875	1,508
74	1,527	2,012	1,747	1,404	74	1,696	2,236	1,942	1,560
75	1,579	2,082	1,809	1,449	75	1,754	2,314	2,009	1,610
76	1,635	2,156	1,872	1,497	76	1,816	2,395	2,079	1,662
77	1,693	2,232	1,938	1,545	77	1,880	2,480	2,153	1,717
78	1,749	2,308	2,003	1,597	78	1,944	2,564	2,226	1,775
79	1,804	2,380	2,066	1,649	79	2,005	2,644	2,295	1,832
80	1,861	2,454	2,131	1,704	80	2,068	2,728	2,367	1,893
81	1,920	2,531	2,199	1,757	81	2,133	2,813	2,443	1,952
82	1,977	2,606	2,263	1,810	82	2,196	2,896	2,514	2,010
83	2,037	2,687	2,333	1,865	83	2,264	2,986	2,592	2,073
84	2,098	2,766	2,401	1,920	84	2,331	3,073	2,668	2,133
85	2,174	2,866	2,489	1,990	85	2,415	3,186	2,765	2,210
86	2,235	2,948	2,559	2,047	86	2,484	3,276	2,843	2,273
87	2,298	3,032	2,632	2,104	87	2,554	3,368	2,924	2,338
88	2,363	3,117	2,706	2,163	88	2,625	3,463	3,007	2,403
89	2,429	3,204	2,781	2,224	89	2,700	3,560	3,091	2,470
90	2,496	3,292	2,858	2,285	90	2,774	3,657	3,175	2,538
91	2,564	3,381	2,935	2,346	91	2,849	3,756	3,261	2,607
92	2,633	3,473	3,014	2,410	92	2,926	3,858	3,349	2,678
93	2,703	3,565	3,095	2,474	93	3,004	3,961	3,438	2,750
94	2,775	3,660	3,176	2,540	94	3,083	4,065	3,530	2,822
95	2,846	3,754	3,259	2,605	95	3,164	4,171	3,622	2,895
96	2,920	3,851	3,344	2,673	96	3,245	4,280	3,715	2,970
97	2,995	3,950	3,429	2,742	97	3,328	4,389	3,810	3,047
98	3,071	4,049	3,516	2,811	98	3,411	4,499	3,907	3,123
99+	3,147	4,151	3,604	2,881	99+	3,496	4,611	4,004	3,201

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: 486-489 and 492
 Male Rates

Rates Effective: 3/1/2021

Attained Age	Preferred				Attained Age	Standard			
	Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
65	1,457	1,922	1,667	1,262	65	1,618	2,135	1,853	1,401
66	1,457	1,922	1,667	1,262	66	1,618	2,135	1,853	1,401
67	1,457	1,922	1,667	1,262	67	1,618	2,135	1,853	1,401
68	1,472	1,942	1,685	1,306	68	1,635	2,158	1,873	1,451
69	1,506	1,985	1,724	1,359	69	1,673	2,207	1,917	1,510
70	1,546	2,037	1,769	1,412	70	1,718	2,264	1,967	1,568
71	1,592	2,100	1,822	1,460	71	1,769	2,334	2,025	1,622
72	1,642	2,165	1,880	1,510	72	1,825	2,406	2,088	1,680
73	1,696	2,235	1,941	1,560	73	1,883	2,485	2,157	1,734
74	1,756	2,314	2,009	1,615	74	1,950	2,572	2,233	1,794
75	1,816	2,395	2,079	1,666	75	2,018	2,661	2,311	1,851
76	1,880	2,479	2,153	1,721	76	2,088	2,754	2,392	1,912
77	1,947	2,568	2,228	1,776	77	2,162	2,853	2,475	1,974
78	2,011	2,654	2,303	1,837	78	2,235	2,948	2,559	2,043
79	2,075	2,736	2,376	1,897	79	2,306	3,040	2,640	2,108
80	2,140	2,823	2,450	1,959	80	2,377	3,138	2,723	2,177
81	2,208	2,911	2,528	2,021	81	2,452	3,234	2,810	2,245
82	2,273	2,997	2,602	2,081	82	2,526	3,331	2,890	2,312
83	2,343	3,091	2,682	2,144	83	2,603	3,433	2,980	2,384
84	2,412	3,181	2,761	2,208	84	2,680	3,534	3,067	2,452
85	2,499	3,297	2,862	2,288	85	2,777	3,664	3,180	2,542
86	2,571	3,390	2,944	2,354	86	2,856	3,768	3,271	2,615
87	2,644	3,486	3,027	2,420	87	2,938	3,873	3,363	2,688
88	2,718	3,584	3,113	2,488	88	3,019	3,982	3,457	2,764
89	2,794	3,685	3,198	2,556	89	3,104	4,093	3,555	2,840
90	2,870	3,785	3,287	2,627	90	3,190	4,206	3,651	2,919
91	2,948	3,888	3,376	2,699	91	3,276	4,320	3,751	2,998
92	3,028	3,994	3,466	2,772	92	3,364	4,437	3,851	3,079
93	3,108	4,101	3,559	2,845	93	3,454	4,556	3,954	3,163
94	3,191	4,209	3,652	2,921	94	3,544	4,675	4,059	3,246
95	3,274	4,318	3,749	2,996	95	3,639	4,798	4,166	3,329
96	3,358	4,429	3,845	3,074	96	3,732	4,921	4,272	3,415
97	3,444	4,543	3,944	3,153	97	3,827	5,047	4,382	3,504
98	3,532	4,656	4,044	3,232	98	3,924	5,174	4,494	3,591
99+	3,619	4,774	4,144	3,313	99+	4,021	5,303	4,605	3,682

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: 3/1/2021

Attained Age	Preferred				Attained Age	Standard			
	Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
65	1,218	1,607	1,394	1,054	65	1,353	1,785	1,550	1,172
66	1,218	1,607	1,394	1,054	66	1,353	1,785	1,550	1,172
67	1,218	1,607	1,394	1,054	67	1,353	1,785	1,550	1,172
68	1,231	1,623	1,409	1,092	68	1,367	1,804	1,566	1,214
69	1,259	1,660	1,442	1,137	69	1,399	1,845	1,602	1,263
70	1,293	1,704	1,479	1,180	70	1,436	1,893	1,644	1,311
71	1,331	1,756	1,524	1,221	71	1,479	1,951	1,693	1,357
72	1,373	1,810	1,572	1,263	72	1,526	2,012	1,746	1,404
73	1,418	1,869	1,622	1,305	73	1,575	2,077	1,803	1,450
74	1,468	1,935	1,680	1,350	74	1,631	2,150	1,867	1,500
75	1,518	2,002	1,739	1,393	75	1,687	2,225	1,932	1,548
76	1,572	2,073	1,800	1,439	76	1,746	2,303	1,999	1,598
77	1,628	2,146	1,863	1,486	77	1,808	2,385	2,070	1,651
78	1,682	2,219	1,926	1,536	78	1,869	2,465	2,140	1,707
79	1,735	2,288	1,987	1,586	79	1,928	2,542	2,207	1,762
80	1,789	2,360	2,049	1,638	80	1,988	2,623	2,276	1,820
81	1,846	2,434	2,114	1,689	81	2,051	2,705	2,349	1,877
82	1,901	2,506	2,176	1,740	82	2,112	2,785	2,417	1,933
83	1,959	2,584	2,243	1,793	83	2,177	2,871	2,492	1,993
84	2,017	2,660	2,309	1,846	84	2,241	2,955	2,565	2,051
85	2,090	2,756	2,393	1,913	85	2,322	3,063	2,659	2,125
86	2,149	2,835	2,461	1,968	86	2,388	3,150	2,734	2,186
87	2,210	2,915	2,531	2,023	87	2,456	3,238	2,812	2,248
88	2,272	2,997	2,602	2,080	88	2,524	3,330	2,891	2,311
89	2,336	3,081	2,674	2,138	89	2,596	3,423	2,972	2,375
90	2,400	3,165	2,748	2,197	90	2,667	3,516	3,053	2,440
91	2,465	3,251	2,822	2,256	91	2,739	3,612	3,136	2,507
92	2,532	3,339	2,898	2,317	92	2,813	3,710	3,220	2,575
93	2,599	3,428	2,976	2,379	93	2,888	3,809	3,306	2,644
94	2,668	3,519	3,054	2,442	94	2,964	3,909	3,394	2,713
95	2,737	3,610	3,134	2,505	95	3,042	4,011	3,483	2,784
96	2,808	3,703	3,215	2,570	96	3,120	4,115	3,572	2,856
97	2,880	3,798	3,297	2,637	97	3,200	4,220	3,663	2,930
98	2,953	3,893	3,381	2,703	98	3,280	4,326	3,757	3,003
99+	3,026	3,991	3,465	2,770	99+	3,362	4,434	3,850	3,078

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: 3/1/2021

Attained Age	Preferred				Attained Age	Standard			
	Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
65	1,401	1,848	1,603	1,213	65	1,556	2,053	1,782	1,347
66	1,401	1,848	1,603	1,213	66	1,556	2,053	1,782	1,347
67	1,401	1,848	1,603	1,213	67	1,556	2,053	1,782	1,347
68	1,415	1,867	1,620	1,256	68	1,572	2,075	1,801	1,395
69	1,448	1,909	1,658	1,307	69	1,609	2,122	1,843	1,452
70	1,487	1,959	1,701	1,358	70	1,652	2,177	1,891	1,508
71	1,531	2,019	1,752	1,404	71	1,701	2,244	1,947	1,560
72	1,579	2,082	1,808	1,452	72	1,755	2,313	2,008	1,615
73	1,631	2,149	1,866	1,500	73	1,811	2,389	2,074	1,667
74	1,688	2,225	1,932	1,553	74	1,875	2,473	2,147	1,725
75	1,746	2,303	1,999	1,602	75	1,940	2,559	2,222	1,780
76	1,808	2,384	2,070	1,655	76	2,008	2,648	2,300	1,838
77	1,872	2,469	2,142	1,708	77	2,079	2,743	2,380	1,898
78	1,934	2,552	2,214	1,766	78	2,149	2,835	2,461	1,964
79	1,995	2,631	2,285	1,824	79	2,217	2,923	2,538	2,027
80	2,058	2,714	2,356	1,884	80	2,286	3,017	2,618	2,093
81	2,123	2,799	2,431	1,943	81	2,358	3,110	2,702	2,159
82	2,186	2,882	2,502	2,001	82	2,429	3,203	2,779	2,223
83	2,253	2,972	2,579	2,062	83	2,503	3,301	2,865	2,292
84	2,319	3,059	2,655	2,123	84	2,577	3,398	2,949	2,358
85	2,403	3,170	2,752	2,200	85	2,670	3,523	3,058	2,444
86	2,472	3,260	2,831	2,263	86	2,746	3,623	3,145	2,514
87	2,542	3,352	2,911	2,327	87	2,825	3,724	3,234	2,585
88	2,613	3,446	2,993	2,392	88	2,903	3,829	3,324	2,658
89	2,687	3,543	3,075	2,458	89	2,985	3,936	3,418	2,731
90	2,760	3,639	3,161	2,526	90	3,067	4,044	3,511	2,807
91	2,835	3,738	3,246	2,595	91	3,150	4,154	3,607	2,883
92	2,912	3,840	3,333	2,665	92	3,235	4,266	3,703	2,961
93	2,988	3,943	3,422	2,736	93	3,321	4,381	3,802	3,041
94	3,068	4,047	3,512	2,809	94	3,408	4,495	3,903	3,121
95	3,148	4,152	3,605	2,881	95	3,499	4,613	4,006	3,201
96	3,229	4,259	3,697	2,956	96	3,588	4,732	4,108	3,284
97	3,312	4,368	3,792	3,032	97	3,680	4,853	4,213	3,369
98	3,396	4,477	3,888	3,108	98	3,773	4,975	4,321	3,453
99+	3,480	4,590	3,985	3,186	99+	3,866	5,099	4,428	3,540

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

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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days 	<p>All but \$1,484</p> <p>All but \$371 a day</p> <p>All but \$742 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>\$371 a day</p> <p>\$742 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$1,484 (Part A Deductible)</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>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</p> <p>First 20 days 21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$185.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$185.50 a day</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/ coinsurance</p>	<p>\$0</p>

**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 61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days	All but \$1,484 All but \$371 a day All but \$742 a day \$0 \$0	\$1,484 (Part A Deductible) \$371 a day \$742 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$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 21st thru 100th day 101st day and after	All approved amounts All but \$185.50 a day \$0	\$0 Up to \$185.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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
<p>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 Remainder of charges</p>	<p>\$0 \$0</p>	<p>\$0 80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>

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 61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days	All but \$1,484 All but \$371 a day All but \$742 a day \$0 \$0	\$1,484 (Part A Deductible) \$371 a day \$742 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$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 21st thru 100th day 101st day and after	All approved amounts All but \$185.50 a day \$0	\$0 Up to \$185.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 (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 \$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 G

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>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 Remainder of charges</p>	<p>\$0 \$0</p>	<p>\$0 80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>

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 61st thru 90th day 91st day and after *While using 60 lifetime reserve days *Once lifetime reserve days are used: *Additional 365 days *Beyond the Additional 365 days	All but \$1,484 All but \$371 a day All but \$742 a day \$0 \$0	\$1,484 (Part A Deductible) \$371 a day \$742 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$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 21st thru 100th day 101st day and after	All approved amounts All but \$185.50 a day \$0	\$0 Up to \$185.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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
<p>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* Remainder of Medicare-Approved amounts</p>	<p>\$0 Generally 80%</p>	<p>\$0 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.</p>	<p>\$203 (Part B Deductible) 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.</p>
<p>Part B Excess Charges (Above Medicare-Approved amounts)</p>	<p>\$0</p>	<p>0%</p>	<p>All costs</p>
<p>BLOOD First 3 pints Next \$203 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts</p>	<p>\$0 \$0 80%</p>	<p>All costs \$0 20%</p>	<p>\$0 \$203 (Part B Deductible) \$0</p>
<p>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</p>	<p>100%</p>	<p>\$0</p>	<p>\$0</p>

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 *Durable medical equipment	100%	\$0	\$0
•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