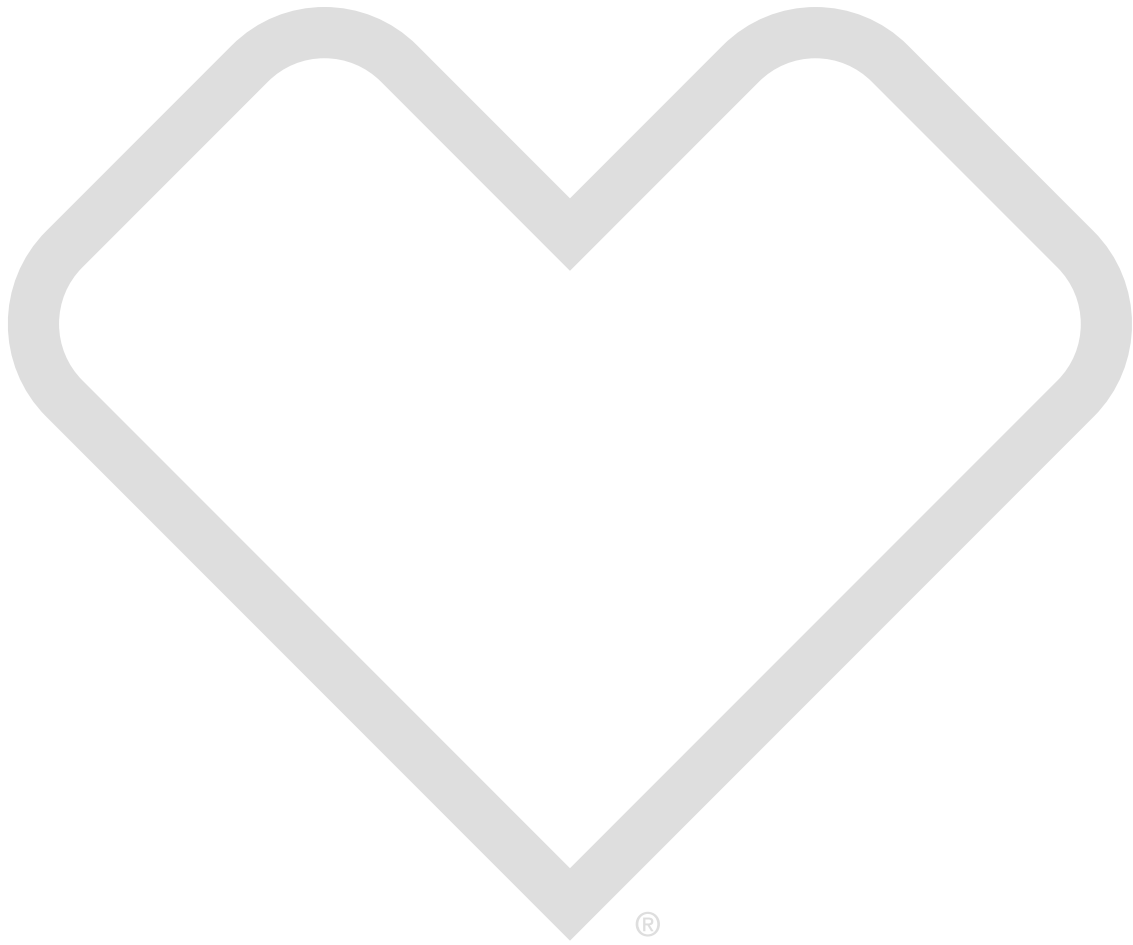




Outline of coverage

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

Wisconsin

Benefit plans: Basic Plan

Rates effective: (01/2023 A)

ACCMS05933WI
(01/2023 A)

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OUTLINE OF MEDICARE SUPPLEMENT INSURANCE
OUTLINE OF COVERAGE FOR POLICY FORM ACCMSP20BC WI

MEDICARE SUPPLEMENT INSURANCE

The Wisconsin Insurance Commissioner has set standards for Medicare Supplement Insurance. This policy meets these standards. It, along with Medicare, may not cover all your medical costs. You should review carefully all policy limitations. For an explanation of these standards and other important information, see *Wisconsin Guide to Health Insurance for People with Medicare*, given to you when you applied for the policy. Do not buy the policy if you did not get this guide.

PREMIUM INFORMATION -We, Accendo Insurance Company can only raise your premium if we raise the premium for all policies like yours in the same geographic area in this state. Your premium will change each year. The new premium will be based on your age.

DISCLOSURES - Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY -This is only an Outline of Coverage describing your policy's most important features. This is not 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 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 of your payments directly to you.

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 fully 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 AND YOU" FOR MORE DETAILS.

Accendo Insurance Company

Annual Premiums

For Use in ZIP Codes: 530-534

Female Rates

Rates effective 1/1/2023

ATTAINED AGE	PREFERRED			
	Basic Policy	Basic Policy with Part B Copayment Rider	Part A Deductible Rider	Part B Excess Rider
Under 65	5,104	3,157	904	15
65	1,591	982	282	5
66	1,591	982	282	5
67	1,591	982	282	5
68	1,608	1,027	287	5
69	1,645	1,074	293	5
70	1,686	1,116	300	5
71	1,738	1,158	309	5
72	1,792	1,198	320	5
73	1,851	1,240	328	5
74	1,916	1,280	341	5
75	1,986	1,323	353	5
76	2,058	1,363	365	5
77	2,125	1,407	378	6
78	2,195	1,451	389	6
79	2,264	1,499	404	6
80	2,336	1,551	415	6
81	2,412	1,600	428	6
82	2,487	1,650	441	6
83	2,562	1,700	455	6
84	2,638	1,750	470	8
85	2,727	1,809	486	8
86	2,806	1,862	499	8
87	2,886	1,915	513	8
88	2,968	1,967	527	8
89	3,049	2,024	543	9
90	3,134	2,079	558	9
91	3,220	2,137	573	9
92	3,309	2,195	589	9
93	3,396	2,251	604	9
94	3,486	2,312	621	9
95	3,578	2,372	635	11
96	3,669	2,436	651	11
97	3,763	2,496	670	11
98	3,859	2,559	686	11
99+	3,957	2,624	703	11

ATTAINED AGE	STANDARD			
	Basic Policy	Basic Policy with Part B Copayment Rider	Part A Deductible Rider	Part B Excess Rider
Under 65	5,671	3,507	1,005	17
65	1,766	1,090	314	5
66	1,766	1,090	314	5
67	1,766	1,090	314	5
68	1,789	1,141	319	5
69	1,828	1,193	325	5
70	1,874	1,240	334	5
71	1,930	1,285	345	5
72	1,992	1,331	354	5
73	2,059	1,377	365	5
74	2,129	1,423	379	5
75	2,208	1,469	392	5
76	2,286	1,516	406	5
77	2,361	1,564	419	8
78	2,439	1,613	433	8
79	2,517	1,666	448	8
80	2,597	1,723	461	8
81	2,680	1,777	476	8
82	2,762	1,834	490	8
83	2,847	1,889	506	8
84	2,932	1,945	522	9
85	3,031	2,010	540	9
86	3,120	2,069	555	9
87	3,207	2,128	570	9
88	3,298	2,187	588	9
89	3,390	2,249	603	11
90	3,481	2,309	621	11
91	3,578	2,373	636	11
92	3,676	2,439	653	11
93	3,774	2,502	671	11
94	3,874	2,569	689	11
95	3,974	2,636	706	12
96	4,077	2,706	725	12
97	4,181	2,773	743	12
98	4,288	2,844	762	12
99+	4,396	2,915	782	12

ATTAINED AGE	PREFERRED		
	Additional Home Health Care Rider	Part B Deductible Rider	Foreign Travel Rider
All	6	226	6

ATTAINED AGE	STANDARD		
	Additional Home Health Care Rider	Part B Deductible Rider	Foreign Travel Rider
All	8	226	8

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 periods, use preferred rates.

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

Accendo Insurance Company

Annual Premiums

For Use in ZIP Codes: 530-534

Male Rates

Rates effective 1/1/2023

ATTAINED AGE	PREFERRED			
	Basic Policy	Basic Policy with Part B Copayment Rider	Part A Deductible Rider	Part B Excess Rider
Under 65	5,869	3,632	1,040	18
65	1,829	1,129	325	6
66	1,829	1,129	325	6
67	1,829	1,129	325	6
68	1,850	1,180	329	6
69	1,892	1,234	335	6
70	1,939	1,283	346	6
71	1,999	1,331	355	6
72	2,061	1,377	367	6
73	2,130	1,427	378	6
74	2,204	1,471	392	6
75	2,284	1,521	406	6
76	2,366	1,568	419	6
77	2,444	1,618	434	8
78	2,523	1,669	448	8
79	2,604	1,725	464	8
80	2,687	1,783	479	8
81	2,773	1,841	491	8
82	2,859	1,897	509	8
83	2,948	1,955	523	8
84	3,034	2,012	540	9
85	3,138	2,080	561	9
86	3,228	2,142	575	9
87	3,319	2,202	591	9
88	3,414	2,262	607	9
89	3,507	2,328	624	11
90	3,605	2,392	643	11
91	3,703	2,456	658	11
92	3,803	2,523	676	11
93	3,906	2,589	696	11
94	4,010	2,657	714	11
95	4,112	2,727	730	12
96	4,219	2,800	750	12
97	4,327	2,871	769	12
98	4,437	2,943	789	12
99+	4,550	3,017	809	12

ATTAINED AGE	STANDARD			
	Basic Policy	Basic Policy with Part B Copayment Rider	Part A Deductible Rider	Part B Excess Rider
Under 65	6,521	4,033	1,156	19
65	2,032	1,253	361	6
66	2,032	1,253	361	6
67	2,032	1,253	361	6
68	2,058	1,311	365	6
69	2,102	1,372	374	6
70	2,155	1,427	385	6
71	2,221	1,479	395	6
72	2,290	1,530	407	6
73	2,367	1,584	419	6
74	2,449	1,635	435	6
75	2,541	1,689	452	6
76	2,628	1,742	467	6
77	2,716	1,797	483	9
78	2,804	1,855	498	9
79	2,895	1,916	516	9
80	2,987	1,981	531	9
81	3,081	2,044	548	9
82	3,177	2,110	564	9
83	3,276	2,172	581	9
84	3,371	2,236	601	11
85	3,486	2,312	622	11
86	3,587	2,379	638	11
87	3,689	2,447	656	11
88	3,794	2,516	675	11
89	3,898	2,585	695	12
90	4,004	2,656	714	12
91	4,112	2,731	732	12
92	4,228	2,804	752	12
93	4,340	2,877	771	12
94	4,455	2,954	793	12
95	4,570	3,031	812	14
96	4,688	3,112	833	14
97	4,809	3,188	857	14
98	4,932	3,270	876	14
99+	5,055	3,352	899	14

ATTAINED AGE	PREFERRED		
	Additional Home Health Care Rider	Part B Deductible Rider	Foreign Travel Rider
All	6	226	6

ATTAINED AGE	STANDARD		
	Additional Home Health Care Rider	Part B Deductible Rider	Foreign Travel Rider
All	8	226	8

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 periods, use preferred rates.

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

Accendo Insurance Company

Annual Premiums

For Use in: Rest of State

Female Rates

Rates effective 1/1/2023

ATTAINED AGE	PREFERRED			
	Basic Policy	Basic Policy with Part B Copayment Rider	Part A Deductible Rider	Part B Excess Rider
Under 65	4,325	2,675	766	13
65	1,348	832	239	4
66	1,348	832	239	4
67	1,348	832	239	4
68	1,363	870	243	4
69	1,394	910	248	4
70	1,429	946	254	4
71	1,473	981	262	4
72	1,519	1,015	271	4
73	1,569	1,051	278	4
74	1,624	1,085	289	4
75	1,683	1,121	299	4
76	1,744	1,155	309	4
77	1,801	1,192	320	5
78	1,860	1,230	330	5
79	1,919	1,270	342	5
80	1,980	1,314	352	5
81	2,044	1,356	363	5
82	2,108	1,398	374	5
83	2,171	1,441	386	5
84	2,236	1,483	398	7
85	2,311	1,533	412	7
86	2,378	1,578	423	7
87	2,446	1,623	435	7
88	2,515	1,667	447	7
89	2,584	1,715	460	8
90	2,656	1,762	473	8
91	2,729	1,811	486	8
92	2,804	1,860	499	8
93	2,878	1,908	512	8
94	2,954	1,959	526	8
95	3,032	2,010	538	9
96	3,109	2,064	552	9
97	3,189	2,115	568	9
98	3,270	2,169	581	9
99+	3,353	2,224	596	9

ATTAINED AGE	STANDARD			
	Basic Policy	Basic Policy with Part B Copayment Rider	Part A Deductible Rider	Part B Excess Rider
Under 65	4,806	2,972	852	14
65	1,497	924	266	4
66	1,497	924	266	4
67	1,497	924	266	4
68	1,516	967	270	4
69	1,549	1,011	275	4
70	1,588	1,051	283	4
71	1,636	1,089	292	4
72	1,688	1,128	300	4
73	1,745	1,167	309	4
74	1,804	1,206	321	4
75	1,871	1,245	332	4
76	1,937	1,285	344	4
77	2,001	1,325	355	7
78	2,067	1,367	367	7
79	2,133	1,412	380	7
80	2,201	1,460	391	7
81	2,271	1,506	403	7
82	2,341	1,554	415	7
83	2,413	1,601	429	7
84	2,485	1,648	442	8
85	2,569	1,703	458	8
86	2,644	1,753	470	8
87	2,718	1,803	483	8
88	2,795	1,853	498	8
89	2,873	1,906	511	9
90	2,950	1,957	526	9
91	3,032	2,011	539	9
92	3,115	2,067	553	9
93	3,198	2,120	569	9
94	3,283	2,177	584	9
95	3,368	2,234	598	10
96	3,455	2,293	614	10
97	3,543	2,350	630	10
98	3,634	2,410	646	10
99+	3,725	2,470	663	10

ATTAINED AGE	PREFERRED		
	Additional Home Health Care Rider	Part B Deductible Rider	Foreign Travel Rider
All	5	226	5

ATTAINED AGE	STANDARD		
	Additional Home Health Care Rider	Part B Deductible Rider	Foreign Travel Rider
All	7	226	7

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 periods, use preferred rates.

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

Accendo Insurance Company

Annual Premiums

For Use in: Rest of State

Male Rates

Rates effective 1/1/2023

ATTAINED AGE	PREFERRED			
	Basic Policy	Basic Policy with Part B Copayment Rider	Part A Deductible Rider	Part B Excess Rider
Under 65	4,974	3,078	881	15
65	1,550	957	275	5
66	1,550	957	275	5
67	1,550	957	275	5
68	1,568	1,000	279	5
69	1,603	1,046	284	5
70	1,643	1,087	293	5
71	1,694	1,128	301	5
72	1,747	1,167	311	5
73	1,805	1,209	320	5
74	1,868	1,247	332	5
75	1,936	1,289	344	5
76	2,005	1,329	355	5
77	2,071	1,371	368	7
78	2,138	1,414	380	7
79	2,207	1,462	393	7
80	2,277	1,511	406	7
81	2,350	1,560	416	7
82	2,423	1,608	431	7
83	2,498	1,657	443	7
84	2,571	1,705	458	8
85	2,659	1,763	475	8
86	2,736	1,815	487	8
87	2,813	1,866	501	8
88	2,893	1,917	514	8
89	2,972	1,973	529	9
90	3,055	2,027	545	9
91	3,138	2,081	558	9
92	3,223	2,138	573	9
93	3,310	2,194	590	9
94	3,398	2,252	605	9
95	3,485	2,311	619	10
96	3,575	2,373	636	10
97	3,667	2,433	652	10
98	3,760	2,494	669	10
99+	3,856	2,557	686	10

ATTAINED AGE	STANDARD			
	Basic Policy	Basic Policy with Part B Copayment Rider	Part A Deductible Rider	Part B Excess Rider
Under 65	5,526	3,418	980	16
65	1,722	1,062	306	5
66	1,722	1,062	306	5
67	1,722	1,062	306	5
68	1,744	1,111	309	5
69	1,781	1,163	317	5
70	1,826	1,209	326	5
71	1,882	1,253	335	5
72	1,941	1,297	345	5
73	2,006	1,342	355	5
74	2,075	1,386	369	5
75	2,153	1,431	383	5
76	2,227	1,476	396	5
77	2,302	1,523	409	8
78	2,376	1,572	422	8
79	2,453	1,624	437	8
80	2,531	1,679	450	8
81	2,611	1,732	464	8
82	2,692	1,788	478	8
83	2,776	1,841	492	8
84	2,857	1,895	509	9
85	2,954	1,959	527	9
86	3,040	2,016	541	9
87	3,126	2,074	556	9
88	3,215	2,132	572	9
89	3,303	2,191	589	10
90	3,393	2,251	605	10
91	3,485	2,314	620	10
92	3,583	2,376	637	10
93	3,678	2,438	653	10
94	3,775	2,503	672	10
95	3,873	2,569	688	12
96	3,973	2,637	706	12
97	4,075	2,702	726	12
98	4,180	2,771	742	12
99+	4,284	2,841	762	12

ATTAINED AGE	PREFERRED		
	Additional Home Health Care Rider	Part B Deductible Rider	Foreign Travel Rider
All	5	226	5

ATTAINED AGE	STANDARD		
	Additional Home Health Care Rider	Part B Deductible Rider	Foreign Travel Rider
All	7	226	7

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 periods, use preferred rates.

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

**ACCENDO INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT INSURANCE**

BASIC PLAN

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.

*NOTICE: When your Medicare Part A hospital benefits are exhausted, the issuer stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits."

**These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

MEDICARE PART A BENEFITS	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies (Does not include personal items)			
First 60 days	All but \$1,600	\$0 or	\$1,600 (Part A Deductible) or
		☐ Part A Deductible Rider**	\$0
61st thru 90th day	All but \$400 a day	\$400 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$800 a day	\$800 a day	\$0
Once lifetime reserve days are used:			
Additional 365 days	\$0	100% of Medicare Eligible Expenses*	\$0
Beyond the Additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$200 a day	Up to \$200 a day	\$0
101st day and after	\$0	\$0	All costs

MEDICARE PART A BENEFITS	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
INPATIENT PSYCHIATRIC CARE Inpatient psychiatric care in a participating psychiatric hospital	190 days per lifetime	175 days per lifetime	All charges not covered by policy nor by Medicare
BLOOD			
First 3 pints	\$0	First 3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

BASIC PLAN

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$226 of Medicare-Approved amounts for covered services
your Part B deductible will have been met for the calendar year.

**These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

MEDICARE PART B BENEFITS	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
MEDICAL EXPENSES Eligible expense for physician's services, in-patient and out-patient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$226 of Medicare-Approved amounts	\$0	\$0 or	\$226 or
		☐ Optional Part B Deductible Rider***	\$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	Charges in excess of 20% up to the limiting charge
		☐ Optional Medicare Copayment or Coinsurance Rider**	Up to \$20 per office visit and up to \$50 per emergency room visit.
		☐ Optional Medicare Part B Excess Charges Rider**	Balance, if any, or expenses if not covered by Medicare or this policy
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$226 of Medicare-Approved amounts*	\$0	\$0 or	\$226 or
		☐ Optional Part B Deductible Rider***	\$0
Remainder of Medicare-Approved amounts	80%	20%	Charges not covered by the policy or Medicare

MEDICARE PART B BENEFITS	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
CLINICAL LABORATORY SERVICES Tests for diagnostic services	100%	\$0	\$0
HOME HEALTH CARE	100% of charges for visits considered medically necessary by Medicare	40 visits or	Charges not covered by policy or Medicare
		☐ Optional Additional Home Health Care Rider**	

**These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

***The Part B Deductible is only available if you were eligible to Medicare prior to January 1st, 2020

BASIC PLAN

OTHER BENEFITS – NOT COVERED BY MEDICARE

	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
First \$120 each calendar year	\$0	\$120	Charges not covered by policy or Medicare
Additional charges	\$0	\$0	
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	\$0 or	All costs or
		☐ Optional Foreign Travel Emergency Rider** (80% to a lifetime maximum benefit of \$50,000)	20% and amounts over the \$50,000 lifetime maximum

**These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

THE FOLLOWING BENEFITS ARE MANDATED BY YOUR STATE:

SKILLED NURSING FACILITY BENEFITS FOR NON-MEDICARE ELIGIBLE CONFINEMENT - We will pay the expenses you incur during any Medicare benefit period for confinement in a Wisconsin state licensed Skilled Nursing Facility, up to a maximum of 30 days. The daily rate payable shall be no less than the maximum daily rate established for skilled nursing care in that facility by the Department of Health and Social Services. Your confinement must be certified initially as Medically Necessary by the attending Physician and recertified every 7 days.

Benefits are not payable for services provided by or paid for by the Veterans Administration or Custodial Care or Skilled Nursing Facility confinement certified by Medicare.

KIDNEY DISEASE BENEFITS - We will pay the expenses you incur for treatment of kidney Disease by dialysis, transplantation and/or donor related services as defined by the Wisconsin Department of Health and Social Services, up to a maximum of \$30,000 each calendar year. We will not pay for charges covered by another policy covering kidney disease expenses or for charges covered by Medicare.

DIABETES BENEFITS - We will pay the usual and customary charges for expenses incurred, and not covered by Medicare, for the installation and use of an insulin infusion pump or other equipment or supplies, including insulin or any prescription medication, used in the treatment of diabetes and coverage of diabetic self-management education programs. Coverage for an insulin infusion pump is limited to one pump per year and is subject to a 30 day trial period prior to purchase.

Benefits are not payable under clause (1) if the equipment and supplies are covered under the Medicare Part D Prescription Drug program, whether or not the insured person is enrolled in a Medicare Part D plan.

CHIROPRACTIC BENEFITS - When Medicare Part B does not pay for Medically Necessary Services received from a Chiropractor, we will 100% of the usual and customary charges for chiropractor services. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other part of this policy.

HOSPITAL AND AMBULATORY SURGICAL CENTER CHARGES - We will pay the usual and customary charges incurred, and anesthetics provided, in conjunction with dental care that is provided to a covered individual in a Hospital or Ambulatory Surgical Center, if any of the Following applies:

- a. you have a chronic disability that is attributable to a mental or physical impairment which results in a substantial functional limitation in an area of your major life activity, and the disability is likely to continue indefinitely.
- b. you have a medical condition that requires hospitalization or general anesthesia for dental care.

BREAST RECONSTRUCTION BENEFITS - We will pay the usual and customary charges Incurred, not payable under Medicare, in the manner recommended by the attending Physician or Oncologist for breast reconstruction of the affected tissue incident to a mastectomy.

COLORECTAL EXAMS – We will pay your expense incurred for colorectal screening exams and lab tests if you are over 50 years of age or if you are under 50 years of age and are symptomatic or in a high-risk category. This coverage is subject to any deductible, coinsurance, co-payment, or other limitation on coverage applicable to other coverages under this policy. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other part of this policy.

CANCER CLINICAL TRIAL -We will provide coverage for the cost of any routine patient care that is administered to an insured in a cancer clinical trial satisfying the following criteria and would be covered under the policy, plan, or contract if the insured were not enrolled in the cancer clinical trial:

- a. The purpose of the trial is to test whether the intervention potentially improves the trial participants' health outcomes.
- b. The treatment provided as part of the trial is given with the intention of improving the trial participants' health outcomes.
- c. The trial has therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
- d. The trial does one of the following:
 1. Tests how to administer a health care service, item, or drug for the treatment of cancer.
 2. Tests responses to a health care service, item, or drug for the treatment of cancer.
 3. Compares the effectiveness of health care services, items, or drugs for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer.
 4. Studies new uses of health care services, items, or drugs for the treatment of cancer.
- e. The trial is approved by one of the following:
 1. A National Institute of Health, or one of its cooperative groups or centers, under the federal department of health and human services.
 2. The Federal Food and Drug Administration.
 3. The Federal Department of Defense.
 4. The Federal Department of Veterans Affairs.

EXCEPTIONS, REDUCTIONS AND LIMITATIONS OF THE POLICY -We will not pay benefits for:

- (1) expenses deemed unnecessary or unreasonable by Medicare, except in the Benefit Provisions and in Optional Riders, if any;
- (2) expenses incurred prior to the coverage effective date;
- (3) drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay);
- (4) custodial care, dental care (except as provided in the mandated benefits) eye or ear examinations to prescribe or fit eyeglasses or hearing aids, routine immunizations, cosmetic surgery or routine foot care;
- (5) services for which a charge is normally not make when there is no insurance;
- (6) nursing home care costs (beyond what is covered by Medicare and the Wisconsin 30-day skilled nursing mandated by Wisconsin 632.895(3);
- (7) home health care above the number of visits covered by Medicare and the 40-visits mandated by Wisconsin 632.895(2), unless you select the Additional Home Health Care Rider;
- (8) care received outside the USA

Benefits will be increased to match any increases in Medicare deductible amounts or co-payment charges. The premium may automatically increase to correspond with these increases.

Renewability of the Policy - We will renew the policy each time you send us the premium. It must be paid on or before the date it is due or during the 31 days that follow.

Your premium will change on the first renewal date that coincides with or follows the anniversary date of the policy.

Material Misrepresentation - in the event of a material misrepresentation, the coverage will be cancelled as of the coverage effective date. A “material misrepresentation” occurs when a condition or combination of conditions you were requested to name on the application was not named and which, if named, would have caused us to deny issuing the coverage. This limitation for material misrepresentation is subject to the Time Limit for Certain defenses provision.

Grievance -A grievance may be made by you or on your behalf in writing to us. A grievance is any dissatisfaction regarding our services, decision to rescind a policy, or claims practices.

IN ADDITION TO THIS OUTLINE OF COVERAGE, ACCENDO INSURANCE COMPANY WILL SEND AN ANNUAL NOTICE TO YOU, 30 DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE CHANGES, WHICH WILL DESCRIBE THESE CHANGES AND THE CHANGES IN YOUR MEDICARE SUPPLEMENT COVERAGE.

MEDICARE SUPPLEMENT PREMIUM INFORMATION

ANNUAL PREMIUM

\$_____

BASIC MEDICARE SUPPLEMENT COVERAGE

OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT POLICY - Each of these riders may be purchased separately.

\$_____

MEDICARE PART A DEDUCTIBLE RIDER -100% of Part A Deductible

\$_____

MEDICARE PART B DEDUCTIBLE RIDER -100% of Part B Deductible
(only available if you are eligible for Medicare prior to January 1, 2020)

\$_____

MEDICARE PART B EXCESS CHARGES RIDER - Difference between what Medicare pays and the amount charged by the provider which shall be no greater than the actual charge or the limiting charge allowed by Medicare, whichever is less.

\$_____

ADDITIONAL HOME HEALTH CARE RIDER - An aggregate of 365 visits per year including those covered by Medicare.

\$_____

FOREIGN TRAVEL EMERGENCY RIDER - After a deductible of not greater than \$250, covers at least 80% of expenses associated with emergency medical care received outside the United States during the first 60 days of a trip with a maximum of at least \$50,000.

\$_____

MEDICARE PART B COPAYMENT OR COINSURANCE RIDER - Pays the Part B coinsurance subject to a copayment or coinsurance of no more than \$20 per office visit and no more than \$50 per emergency room visit or the Medicare Part B coinsurance that is in addition to the Medicare Part B medical deductible and in addition to out-of-pocket maximums.

\$_____

TOTAL FOR BASIC POLICY, POLICY FEE AND SELECTED OPTIONAL RIDERS

Total Premium, if other than Annual Mode (at time of application), including premium for any Optional Rider selected above:

\$_____ EFT \$_____ Quarterly \$_____ Semi-annual