ACE PROPERTY & CASUALTY INSURANCE COMPANY
Outline of Medicare Supplement Coverage
Benefit Plans A, F, G, N and High Deductible Plan G

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available in your state. 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	G[1]	K	L	M	N	C	F	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 2024[2]						$7060[2]	$3530[2]					

[1]Plans F and G also have a high deductible option which requires first paying a plan deductible of $2800 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.

Effective 07-01-2023

ACE PROPERTY & CASUALTY INSURANCE COMPANY

Policy Fee $25

MISSOURI Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 630-633, 640-641

	Preferred				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
Under 65	2,138	3,010	2,160	865	1,662
65	2,138	3,010	2,160	865	1,662
66	2,138	3,010	2,160	865	1,662
67	2,138	3,010	2,160	865	1,662
68	2,180	3,070	2,203	882	1,711
69	2,224	3,131	2,246	899	1,762
70	2,270	3,194	2,292	917	1,814
71	2,315	3,259	2,338	936	1,870
72	2,371	3,341	2,396	960	1,926
73	2,431	3,424	2,456	983	1,984
74	2,494	3,509	2,518	1,008	2,042
75	2,555	3,598	2,581	1,033	2,105
76	2,620	3,686	2,645	1,060	2,168
77	2,696	3,798	2,725	1,092	2,232
78	2,779	3,912	2,807	1,124	2,299
79	2,862	4,030	2,891	1,158	2,368
80	2,947	4,150	2,977	1,193	2,440
81	3,036	4,276	3,066	1,229	2,513
82	3,127	4,403	3,160	1,265	2,588
83	3,236	4,558	3,270	1,309	2,678
84	3,349	4,716	3,384	1,356	2,772
85	3,467	4,882	3,503	1,403	2,870
86	3,588	5,052	3,625	1,452	2,970
87	3,715	5,228	3,751	1,504	3,073
88	3,845	5,411	3,883	1,556	3,181
89	3,978	5,600	4,019	1,610	3,294
90	4,117	5,797	4,159	1,666	3,409
91	4,262	6,000	4,306	1,724	3,529
92	4,411	6,210	4,456	1,786	3,653
93	4,565	6,427	4,610	1,847	3,780
94	4,726	6,653	4,772	1,912	3,913
95	4,890	6,886	4,939	1,979	4,050
96	5,062	7,127	5,113	2,048	4,192
97	5,239	7,374	5,292	2,119	4,338
98	5,422	7,633	5,477	2,192	4,489
99	5,612	7,900	5,669	2,270	4,646

	Standard				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
Under 65	2,460	3,461	2,484	996	1,909
65	2,460	3,461	2,484	996	1,909
66	2,460	3,461	2,484	996	1,909
67	2,460	3,461	2,484	996	1,909
68	2,508	3,530	2,534	1,014	1,968
69	2,558	3,601	2,584	1,033	2,028
70	2,610	3,674	2,635	1,055	2,087
71	2,662	3,748	2,688	1,076	2,149
72	2,728	3,842	2,755	1,103	2,214
73	2,796	3,937	2,825	1,130	2,281
74	2,867	4,036	2,896	1,159	2,350
75	2,938	4,138	2,969	1,189	2,420
76	3,013	4,240	3,043	1,219	2,494
77	3,102	4,368	3,134	1,254	2,567
78	3,197	4,499	3,228	1,292	2,645
79	3,292	4,633	3,324	1,333	2,724
80	3,390	4,772	3,424	1,372	2,804
81	3,492	4,916	3,528	1,412	2,888
82	3,596	5,064	3,632	1,454	2,976
83	3,722	5,240	3,761	1,506	3,080
84	3,853	5,423	3,893	1,560	3,188
85	3,988	5,612	4,028	1,614	3,300
86	4,127	5,810	4,169	1,669	3,414
87	4,272	6,013	4,315	1,728	3,534
88	4,422	6,223	4,466	1,789	3,660
89	4,573	6,440	4,621	1,850	3,787
90	4,735	6,667	4,783	1,916	3,920
91	4,902	6,900	4,951	1,984	4,057
92	5,074	7,141	5,125	2,052	4,200
93	5,250	7,391	5,303	2,124	4,348
94	5,435	7,651	5,489	2,198	4,500
95	5,623	7,919	5,682	2,274	4,657
96	5,821	8,195	5,879	2,356	4,822
97	6,024	8,480	6,085	2,438	4,988
98	6,235	8,778	6,298	2,522	5,164
99	6,455	9,085	6,520	2,610	5,345

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: Divide by 12

ACE PROPERTY & CASUALTY INSURANCE COMPANY

MISSOURI Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 630-633, 640-641

	Preferred				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
Under 65	1,925	2,709	1,944	779	1,496
65	1,925	2,709	1,944	779	1,496
66	1,925	2,709	1,944	779	1,496
67	1,925	2,709	1,944	779	1,496
68	1,962	2,763	1,983	794	1,540
69	2,001	2,818	2,022	809	1,585
70	2,043	2,875	2,063	825	1,633
71	2,083	2,933	2,104	842	1,683
72	2,134	3,007	2,157	864	1,733
73	2,188	3,081	2,211	885	1,785
74	2,244	3,158	2,266	907	1,838
75	2,299	3,238	2,323	930	1,894
76	2,358	3,318	2,380	954	1,952
77	2,427	3,418	2,453	983	2,009
78	2,501	3,521	2,526	1,012	2,069
79	2,576	3,627	2,602	1,042	2,131
80	2,652	3,735	2,679	1,074	2,196
81	2,732	3,848	2,759	1,106	2,262
82	2,814	3,963	2,844	1,138	2,330
83	2,913	4,102	2,943	1,178	2,411
84	3,014	4,244	3,046	1,220	2,495
85	3,120	4,393	3,153	1,263	2,583
86	3,229	4,547	3,263	1,307	2,673
87	3,344	4,706	3,376	1,353	2,766
88	3,460	4,870	3,495	1,401	2,863
89	3,580	5,040	3,617	1,449	2,965
90	3,705	5,217	3,743	1,499	3,068
91	3,836	5,400	3,875	1,552	3,176
92	3,970	5,589	4,010	1,607	3,288
93	4,108	5,784	4,149	1,662	3,402
94	4,253	5,988	4,295	1,720	3,522
95	4,401	6,197	4,445	1,781	3,645
96	4,555	6,414	4,602	1,844	3,772
97	4,715	6,637	4,763	1,907	3,904
98	4,879	6,870	4,929	1,973	4,040
99	5,051	7,110	5,102	2,043	4,182

	Standard				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
Under 65	2,214	3,115	2,236	896	1,718
65	2,214	3,115	2,236	896	1,718
66	2,214	3,115	2,236	896	1,718
67	2,214	3,115	2,236	896	1,718
68	2,257	3,177	2,281	913	1,771
69	2,303	3,241	2,325	930	1,825
70	2,349	3,307	2,372	949	1,878
71	2,395	3,373	2,419	969	1,934
72	2,455	3,458	2,480	993	1,993
73	2,516	3,543	2,542	1,017	2,053
74	2,580	3,632	2,606	1,043	2,115
75	2,644	3,724	2,672	1,070	2,178
76	2,712	3,816	2,739	1,097	2,244
77	2,792	3,931	2,821	1,129	2,310
78	2,877	4,049	2,905	1,163	2,380
79	2,962	4,170	2,992	1,200	2,452
80	3,051	4,295	3,081	1,234	2,524
81	3,143	4,425	3,175	1,271	2,600
82	3,237	4,558	3,269	1,309	2,678
83	3,350	4,716	3,385	1,355	2,772
84	3,468	4,881	3,504	1,404	2,870
85	3,589	5,051	3,626	1,453	2,970
86	3,714	5,229	3,752	1,502	3,073
87	3,845	5,412	3,884	1,555	3,181
88	3,980	5,601	4,020	1,610	3,294
89	4,116	5,796	4,159	1,665	3,408
90	4,262	6,000	4,305	1,725	3,528
91	4,412	6,210	4,456	1,785	3,651
92	4,566	6,427	4,613	1,847	3,780
93	4,725	6,652	4,773	1,912	3,913
94	4,891	6,886	4,940	1,979	4,050
95	5,061	7,127	5,114	2,047	4,191
96	5,239	7,375	5,291	2,120	4,339
97	5,422	7,632	5,477	2,195	4,490
98	5,612	7,900	5,668	2,270	4,647
99	5,809	8,177	5,868	2,349	4,810

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: Divide by 12

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

MISSOURI Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 630-633, 640-641

	Preferred				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
Under 65	1,901	2,675	1,920	769	1,476
65	1,901	2,675	1,920	769	1,476
66	1,901	2,675	1,920	769	1,476
67	1,901	2,675	1,920	769	1,476
68	1,939	2,729	1,958	784	1,522
69	1,978	2,784	1,997	799	1,567
70	2,017	2,839	2,036	816	1,614
71	2,057	2,897	2,078	832	1,662
72	2,108	2,970	2,130	853	1,711
73	2,161	3,043	2,183	874	1,763
74	2,216	3,119	2,238	896	1,816
75	2,270	3,198	2,294	918	1,871
76	2,328	3,277	2,352	942	1,927
77	2,398	3,376	2,422	970	1,985
78	2,470	3,478	2,495	1,000	2,044
79	2,544	3,581	2,569	1,030	2,105
80	2,620	3,689	2,646	1,060	2,168
81	2,699	3,800	2,726	1,092	2,233
82	2,780	3,913	2,808	1,124	2,300
83	2,878	4,050	2,906	1,164	2,381
84	2,977	4,192	3,008	1,205	2,464
85	3,082	4,338	3,113	1,247	2,551
86	3,190	4,490	3,222	1,290	2,640
87	3,301	4,648	3,335	1,336	2,732
88	3,418	4,810	3,451	1,382	2,828
89	3,535	4,979	3,572	1,430	2,927
90	3,660	5,153	3,697	1,481	3,030
91	3,788	5,333	3,827	1,532	3,137
92	3,920	5,520	3,960	1,586	3,247
93	4,057	5,713	4,098	1,642	3,360
94	4,200	5,914	4,242	1,699	3,479
95	4,346	6,120	4,391	1,758	3,600
96	4,499	6,335	4,544	1,820	3,726
97	4,657	6,556	4,704	1,884	3,857
98	4,819	6,785	4,868	1,949	3,991
99	4,988	7,022	5,039	2,017	4,130

	Standard				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
Under 65	2,186	3,076	2,208	884	1,698
65	2,186	3,076	2,208	884	1,698
66	2,186	3,076	2,208	884	1,698
67	2,186	3,076	2,208	884	1,698
68	2,230	3,138	2,252	902	1,750
69	2,274	3,202	2,297	918	1,802
70	2,320	3,265	2,342	938	1,855
71	2,365	3,331	2,389	958	1,910
72	2,424	3,415	2,449	980	1,968
73	2,485	3,499	2,510	1,006	2,028
74	2,549	3,587	2,574	1,031	2,088
75	2,611	3,677	2,639	1,056	2,152
76	2,678	3,768	2,705	1,084	2,216
77	2,756	3,882	2,785	1,115	2,281
78	2,840	4,000	2,869	1,148	2,351
79	2,926	4,118	2,954	1,184	2,420
80	3,013	4,242	3,043	1,219	2,494
81	3,104	4,370	3,136	1,255	2,568
82	3,197	4,501	3,229	1,292	2,645
83	3,308	4,657	3,343	1,338	2,738
84	3,425	4,820	3,460	1,386	2,833
85	3,544	4,988	3,581	1,434	2,933
86	3,668	5,165	3,706	1,483	3,035
87	3,797	5,345	3,835	1,536	3,142
88	3,930	5,532	3,970	1,590	3,253
89	4,066	5,725	4,108	1,645	3,366
90	4,208	5,926	4,252	1,704	3,486
91	4,357	6,133	4,402	1,763	3,607
92	4,510	6,348	4,555	1,824	3,733
93	4,666	6,570	4,712	1,888	3,864
94	4,831	6,800	4,879	1,954	4,001
95	4,998	7,039	5,050	2,022	4,141
96	5,173	7,284	5,226	2,093	4,285
97	5,356	7,538	5,408	2,167	4,434
98	5,543	7,802	5,598	2,242	4,590
99	5,737	8,075	5,795	2,320	4,751

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: Divide by 12

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

MISSOURI Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 630-633, 640-641

	Preferred				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
Under 65	1,711	2,407	1,728	692	1,328
65	1,711	2,407	1,728	692	1,328
66	1,711	2,407	1,728	692	1,328
67	1,711	2,407	1,728	692	1,328
68	1,745	2,456	1,763	705	1,369
69	1,780	2,506	1,797	719	1,410
70	1,815	2,555	1,833	734	1,453
71	1,851	2,607	1,871	748	1,496
72	1,898	2,673	1,917	768	1,540
73	1,945	2,739	1,965	786	1,587
74	1,995	2,807	2,014	807	1,634
75	2,043	2,878	2,065	826	1,684
76	2,095	2,949	2,117	848	1,734
77	2,158	3,038	2,179	873	1,786
78	2,223	3,130	2,245	900	1,839
79	2,290	3,223	2,312	927	1,894
80	2,358	3,320	2,381	954	1,952
81	2,429	3,420	2,454	983	2,010
82	2,502	3,522	2,527	1,012	2,070
83	2,590	3,645	2,616	1,048	2,143
84	2,679	3,772	2,708	1,084	2,217
85	2,773	3,904	2,802	1,122	2,296
86	2,871	4,041	2,900	1,161	2,376
87	2,971	4,183	3,001	1,202	2,459
88	3,076	4,329	3,106	1,244	2,546
89	3,182	4,481	3,215	1,287	2,634
90	3,294	4,638	3,327	1,333	2,727
91	3,410	4,800	3,444	1,379	2,823
92	3,528	4,968	3,564	1,428	2,922
93	3,651	5,142	3,688	1,477	3,024
94	3,780	5,322	3,818	1,529	3,131
95	3,912	5,508	3,952	1,582	3,240
96	4,049	5,701	4,090	1,638	3,353
97	4,191	5,900	4,234	1,696	3,471
98	4,337	6,106	4,382	1,754	3,592
99	4,490	6,320	4,535	1,815	3,717

	Standard				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
Under 65	1,968	2,768	1,987	796	1,528
65	1,968	2,768	1,987	796	1,528
66	1,968	2,768	1,987	796	1,528
67	1,968	2,768	1,987	796	1,528
68	2,007	2,824	2,027	812	1,575
69	2,047	2,881	2,067	826	1,622
70	2,088	2,939	2,108	845	1,670
71	2,129	2,998	2,150	862	1,719
72	2,182	3,074	2,204	882	1,771
73	2,237	3,149	2,259	905	1,825
74	2,294	3,228	2,317	928	1,879
75	2,350	3,309	2,375	950	1,936
76	2,411	3,391	2,434	975	1,995
77	2,481	3,494	2,507	1,003	2,053
78	2,556	3,600	2,582	1,034	2,116
79	2,633	3,707	2,659	1,066	2,178
80	2,712	3,818	2,739	1,097	2,244
81	2,794	3,933	2,822	1,130	2,311
82	2,877	4,051	2,906	1,163	2,380
83	2,978	4,191	3,009	1,204	2,465
84	3,082	4,338	3,114	1,247	2,550
85	3,189	4,490	3,223	1,291	2,640
86	3,302	4,648	3,335	1,335	2,731
87	3,417	4,810	3,452	1,382	2,827
88	3,537	4,979	3,573	1,431	2,928
89	3,659	5,153	3,697	1,481	3,029
90	3,788	5,333	3,826	1,534	3,137
91	3,921	5,520	3,961	1,587	3,246
92	4,059	5,713	4,100	1,642	3,360
93	4,199	5,913	4,241	1,699	3,478
94	4,348	6,120	4,391	1,758	3,601
95	4,498	6,335	4,545	1,820	3,727
96	4,656	6,556	4,703	1,884	3,857
97	4,820	6,785	4,868	1,950	3,991
98	4,989	7,022	5,038	2,017	4,131
99	5,163	7,267	5,215	2,088	4,276

Modal Factors: Semi Annual: 0.5000 Quarterly: 0.25000 Monthly: Divide by 12

Household Discount Factor .93

PREMIUM INFORMATION

ACE Property & Casualty Insurance Company may change your premium on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class. Class is defined as issue age, sex, underwriting class, state of issue, and your most recent zip code of residence in the state of issue. Premiums are based on your issue age.

DISCLOSURES

Use this outline to compare benefits and premiums 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 ACE Property & Casualty Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to: ACE Property & Casualty Insurance Company, Medicare Supplement Administration, P.O. Box 10858, Clearwater, Florida 33757-8858. 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, less any claims paid.

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

This policy may not fully cover all of your medical costs. Neither ACE Property & Casualty 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.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. ACE Property & Casualty Insurance 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. Please refer to your policy for details.

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 $1632	$0	$1632 (Part A deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 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 co-payment/ 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 $240 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 $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 Generally 80%	$0 Generally 20%	$240 (Part B deductible) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 $0 80%	All costs $0 20%	$0 $240 (Part B deductible) $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 — Durable medical equipment First $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $240 (Part B deductible) $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 $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

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

*Once you have been billed $240 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 $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $240 (Part B deductible) Generally 20%	 $0 $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $240 of Medicare Approved amounts* Remainder of Medicare Approved amounts	 $0 $0 80%	 All costs $240 (Part B deductible) 20%	 $0 $0 $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN F

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 $240 of Medicare Approved Amounts*	$0	$240 (Part B deductible)	$0
- 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

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 $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G
MEDICARE (PART B) – MEDICAL SERVICES-PER – CALENDAR YEAR

*Once you have been billed $240 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 $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 $240 (Unless Part B deductible has been met) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 $240 (Unless Part B deductible has been met) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN G

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 $240 of Medicare Approved Amounts*	$0	$0	$240 (Unless Part B deductible has been met)
- 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

HIGH DEDUCTIBLE 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. **This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE ** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN G

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

*Once you have been billed $240 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.

**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE ** 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 $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 Generally 80%	$0 Generally 20%	$240 (Unless Part B deductible has been met) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $240 of Medicare Approved amounts* Remainder of Medicare Approved amounts	$0 $0 80%	All costs $0 20%	$0 $240 (Unless Part B deductible has been met) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE ** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment - First $240 of Medicare Approved Amounts*	$0	$0	$240 (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE ** 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 $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

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

*Once you have been billed $240 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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare Approved Amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

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 - First $240 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $240 (Part B deductible) $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 Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.