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)			80%	80%				80%	80%	80%	80%	
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 08-01-2023

ACE PROPERTY & CASUALTY INSURANCE COMPANY

Policy Fee $25

NEW HAMPSHIRE Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL OF STATE

	Preferred				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
Under 65	7,824	10,520	7,983	3,194	6,037
65	2,212	2,895	2,257	904	1,707
66	2,212	2,895	2,257	904	1,707
67	2,212	2,895	2,257	904	1,707
68	2,212	2,976	2,257	904	1,707
69	2,279	3,064	2,325	931	1,758
70	2,347	3,156	2,395	959	1,811
71	2,418	3,252	2,468	987	1,864
72	2,501	3,363	2,552	1,022	1,929
73	2,589	3,483	2,642	1,057	1,996
74	2,679	3,602	2,733	1,094	2,067
75	2,787	3,748	2,845	1,137	2,149
76	2,899	3,898	2,958	1,184	2,235
77	3,014	4,054	3,076	1,230	2,324
78	3,134	4,215	3,199	1,281	2,417
79	3,259	4,385	3,326	1,331	2,514
80	3,392	4,559	3,461	1,385	2,613
81	3,542	4,765	3,615	1,446	2,732
82	3,702	4,978	3,778	1,510	2,854
83	3,870	5,201	3,948	1,579	2,984
84	4,042	5,435	4,125	1,650	3,117
85	4,225	5,679	4,311	1,725	3,259
86	4,415	5,936	4,505	1,803	3,406
87	4,613	6,202	4,707	1,884	3,558
88	4,821	6,481	4,919	1,967	3,717
89	5,038	6,773	5,141	2,056	3,885
90	5,265	7,078	5,372	2,149	4,061
91	5,500	7,397	5,613	2,246	4,242
92	5,749	7,730	5,867	2,347	4,436
93	6,007	8,078	6,129	2,452	4,634
94	6,278	8,442	6,405	2,563	4,844
95	6,560	8,823	6,694	2,678	5,061
96	6,855	9,219	6,995	2,797	5,290
97	7,164	9,636	7,309	2,924	5,527
98	7,487	10,069	7,640	3,055	5,778
99	7,824	10,520	7,983	3,194	6,037

	Standard				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
Under 65	8,997	12,099	9,181	3,672	6,943
65	2,544	3,331	2,596	1,039	1,962
66	2,544	3,331	2,596	1,039	1,962
67	2,544	3,331	2,596	1,039	1,962
68	2,544	3,420	2,596	1,039	1,962
69	2,621	3,523	2,674	1,070	2,022
70	2,699	3,630	2,754	1,103	2,082
71	2,781	3,738	2,837	1,135	2,145
72	2,877	3,869	2,935	1,175	2,218
73	2,978	4,005	3,038	1,215	2,296
74	3,082	4,144	3,145	1,258	2,374
75	3,204	4,311	3,269	1,308	2,471
76	3,334	4,482	3,402	1,362	2,569
77	3,467	4,661	3,537	1,415	2,672
78	3,605	4,847	3,678	1,472	2,780
79	3,750	5,041	3,825	1,531	2,889
80	3,900	5,243	3,980	1,592	3,005
81	4,075	5,479	4,158	1,664	3,142
82	4,257	5,725	4,344	1,739	3,281
83	4,449	5,982	4,539	1,817	3,432
84	4,648	6,250	4,743	1,898	3,586
85	4,859	6,533	4,957	1,982	3,747
86	5,077	6,827	5,181	2,074	3,917
87	5,306	7,134	5,414	2,165	4,092
88	5,545	7,454	5,657	2,264	4,275
89	5,793	7,788	5,912	2,364	4,470
90	6,054	8,141	6,178	2,473	4,669
91	6,324	8,508	6,454	2,581	4,882
92	6,611	8,892	6,746	2,699	5,100
93	6,908	9,290	7,048	2,820	5,331
94	7,219	9,709	7,367	2,946	5,570
95	7,544	10,146	7,698	3,079	5,821
96	7,883	10,601	8,044	3,217	6,083
97	8,238	11,079	8,407	3,363	6,357
98	8,610	11,578	8,785	3,513	6,642
99	8,997	12,099	9,181	3,672	6,943

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

Effective 08-01-2023

ACE PROPERTY & CASUALTY INSURANCE COMPANY

Policy Fee $25

NEW HAMPSHIRE Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL OF STATE

	Preferred				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
Under 65	6,953	9,351	7,096	2,839	5,368
65	1,967	2,574	2,007	804	1,516
66	1,967	2,574	2,007	804	1,516
67	1,967	2,574	2,007	804	1,516
68	1,967	2,644	2,007	804	1,516
69	2,026	2,723	2,067	827	1,562
70	2,087	2,806	2,129	852	1,609
71	2,149	2,890	2,192	876	1,656
72	2,224	2,989	2,269	909	1,714
73	2,301	3,095	2,348	940	1,774
74	2,382	3,204	2,431	973	1,837
75	2,478	3,333	2,528	1,011	1,909
76	2,577	3,465	2,630	1,052	1,985
77	2,679	3,602	2,733	1,094	2,065
78	2,787	3,748	2,845	1,137	2,149
79	2,898	3,898	2,957	1,184	2,235
80	3,014	4,052	3,076	1,230	2,322
81	3,149	4,234	3,214	1,285	2,428
82	3,291	4,425	3,358	1,342	2,538
83	3,438	4,623	3,508	1,403	2,652
84	3,593	4,831	3,667	1,467	2,771
85	3,754	5,049	3,831	1,533	2,897
86	3,924	5,275	4,004	1,602	3,027
87	4,102	5,513	4,185	1,674	3,162
88	4,287	5,762	4,374	1,749	3,306
89	4,478	6,020	4,568	1,828	3,454
90	4,679	6,292	4,775	1,909	3,608
91	4,889	6,575	4,989	1,996	3,772
92	5,109	6,872	5,213	2,085	3,942
93	5,340	7,181	5,449	2,179	4,119
94	5,580	7,504	5,694	2,278	4,306
95	5,832	7,842	5,951	2,381	4,498
96	6,093	8,194	6,218	2,486	4,702
97	6,369	8,563	6,499	2,598	4,913
98	6,655	8,949	6,791	2,716	5,134
99	6,953	9,351	7,096	2,839	5,368

	Standard				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
Under 65	7,996	10,756	8,159	3,264	6,172
65	2,262	2,959	2,308	923	1,744
66	2,262	2,959	2,308	923	1,744
67	2,262	2,959	2,308	923	1,744
68	2,262	3,040	2,308	923	1,744
69	2,330	3,132	2,377	951	1,797
70	2,400	3,226	2,448	980	1,851
71	2,471	3,323	2,521	1,009	1,906
72	2,557	3,439	2,609	1,043	1,972
73	2,647	3,559	2,701	1,080	2,039
74	2,738	3,683	2,794	1,118	2,111
75	2,848	3,832	2,906	1,163	2,197
76	2,964	3,984	3,024	1,210	2,284
77	3,082	4,144	3,145	1,258	2,374
78	3,204	4,309	3,269	1,308	2,471
79	3,333	4,482	3,401	1,360	2,569
80	3,465	4,661	3,536	1,415	2,672
81	3,622	4,869	3,696	1,480	2,793
82	3,784	5,089	3,862	1,544	2,918
83	3,954	5,317	4,035	1,614	3,048
84	4,132	5,556	4,216	1,687	3,188
85	4,318	5,807	4,406	1,763	3,330
86	4,513	6,069	4,605	1,842	3,482
87	4,716	6,342	4,812	1,925	3,637
88	4,928	6,625	5,028	2,011	3,802
89	5,149	6,924	5,255	2,102	3,972
90	5,382	7,236	5,492	2,197	4,153
91	5,624	7,562	5,739	2,295	4,337
92	5,876	7,902	5,996	2,399	4,533
93	6,141	8,259	6,266	2,506	4,737
94	6,418	8,629	6,549	2,620	4,951
95	6,706	9,018	6,843	2,737	5,173
96	7,007	9,422	7,151	2,860	5,406
97	7,322	9,849	7,471	2,989	5,651
98	7,653	10,291	7,808	3,124	5,904
99	7,996	10,756	8,159	3,264	6,172

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

PREMIUM INFORMATION

We, ACE Property & Casualty Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this State.

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*	$0	$0	$240 (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 $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

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 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $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*	$0	$240 (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 $240 of Medicare Approved amounts*	$0	$240 (Part B deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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

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

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.