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 03-01-2023

ACE PROPERTY & CASUALTY INSURANCE COMPANY

Policy Fee $25

NEVADA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 889-891

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
65	1,731	2,024	1,747	700	1,297
66	1,731	2,024	1,747	700	1,297
67	1,731	2,024	1,747	700	1,297
68	1,731	2,081	1,747	700	1,303
69	1,740	2,143	1,757	702	1,320
70	1,763	2,207	1,779	713	1,346
71	1,815	2,274	1,834	733	1,386
72	1,879	2,352	1,896	759	1,433
73	1,944	2,435	1,963	785	1,483
74	2,012	2,519	2,031	813	1,535
75	2,093	2,620	2,113	845	1,598
76	2,176	2,726	2,198	880	1,661
77	2,262	2,836	2,286	914	1,727
78	2,354	2,948	2,376	951	1,797
79	2,447	3,067	2,472	989	1,868
80	2,544	3,189	2,572	1,028	1,941
81	2,659	3,332	2,686	1,074	2,030
82	2,780	3,481	2,807	1,122	2,121
83	2,904	3,638	2,934	1,174	2,217
84	3,035	3,801	3,064	1,226	2,317
85	3,171	3,972	3,204	1,282	2,421
86	3,314	4,152	3,347	1,340	2,531
87	3,463	4,338	3,498	1,400	2,644
88	3,619	4,533	3,655	1,462	2,762
89	3,781	4,737	3,820	1,528	2,887
90	3,950	4,950	3,992	1,598	3,017
91	4,129	5,173	4,171	1,669	3,152
92	4,315	5,406	4,359	1,744	3,296
93	4,509	5,650	4,554	1,822	3,443
94	4,712	5,904	4,759	1,905	3,599
95	4,925	6,170	4,974	1,990	3,761
96	5,147	6,447	5,198	2,079	3,930
97	5,378	6,739	5,431	2,172	4,108
98	5,620	7,042	5,676	2,271	4,294
99	5,873	7,357	5,932	2,373	4,487

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
65	1,990	2,329	2,009	805	1,491
66	1,990	2,329	2,009	805	1,491
67	1,990	2,329	2,009	805	1,491
68	1,990	2,393	2,009	805	1,498
69	2,001	2,464	2,021	809	1,519
70	2,028	2,538	2,047	820	1,547
71	2,088	2,614	2,108	843	1,593
72	2,161	2,705	2,182	873	1,649
73	2,235	2,800	2,258	903	1,707
74	2,313	2,898	2,337	935	1,764
75	2,406	3,015	2,429	972	1,836
76	2,503	3,134	2,528	1,012	1,909
77	2,601	3,260	2,628	1,052	1,985
78	2,707	3,390	2,734	1,094	2,066
79	2,814	3,526	2,843	1,137	2,146
80	2,928	3,667	2,957	1,182	2,233
81	3,058	3,832	3,089	1,237	2,335
82	3,196	4,004	3,228	1,291	2,439
83	3,339	4,184	3,373	1,349	2,550
84	3,490	4,371	3,525	1,410	2,664
85	3,647	4,569	3,684	1,472	2,784
86	3,812	4,774	3,850	1,541	2,910
87	3,981	4,989	4,023	1,609	3,041
88	4,161	5,213	4,204	1,682	3,177
89	4,348	5,446	4,392	1,757	3,321
90	4,544	5,693	4,590	1,837	3,469
91	4,750	5,950	4,796	1,919	3,627
92	4,963	6,219	5,013	2,005	3,789
93	5,186	6,497	5,238	2,095	3,961
94	5,420	6,790	5,474	2,189	4,139
95	5,664	7,095	5,720	2,288	4,326
96	5,918	7,414	5,977	2,390	4,520
97	6,184	7,748	6,247	2,498	4,724
98	6,463	8,097	6,528	2,611	4,936
99	6,754	8,462	6,822	2,729	5,160

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY

NEVADA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 889-891

	Preferred						Standard				
				HD						HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
65	1,537	1,797	1,551	621	1,151	65	1,767	2,068	1,784	714	1,323
66	1,537	1,797	1,551	621	1,151	66	1,767	2,068	1,784	714	1,323
67	1,537	1,797	1,551	621	1,151	67	1,767	2,068	1,784	714	1,323
68	1,537	1,848	1,551	621	1,157	68	1,767	2,124	1,784	714	1,330
69	1,545	1,903	1,560	623	1,172	69	1,777	2,188	1,795	718	1,349
70	1,566	1,960	1,580	633	1,195	70	1,800	2,253	1,817	728	1,374
71	1,611	2,019	1,628	651	1,230	71	1,853	2,321	1,872	749	1,415
72	1,668	2,088	1,683	674	1,272	72	1,919	2,402	1,937	775	1,464
73	1,726	2,162	1,743	697	1,317	73	1,985	2,486	2,005	802	1,515
74	1,786	2,236	1,803	722	1,363	74	2,054	2,573	2,075	830	1,567
75	1,858	2,327	1,876	751	1,418	75	2,137	2,677	2,157	863	1,630
76	1,932	2,421	1,951	781	1,474	76	2,222	2,783	2,245	899	1,695
77	2,008	2,518	2,029	811	1,533	77	2,309	2,895	2,333	934	1,762
78	2,090	2,617	2,110	845	1,595	78	2,404	3,010	2,427	971	1,834
79	2,173	2,723	2,195	878	1,659	79	2,499	3,130	2,524	1,010	1,906
80	2,259	2,831	2,284	913	1,723	80	2,599	3,256	2,626	1,050	1,983
81	2,361	2,958	2,385	954	1,802	81	2,715	3,402	2,743	1,098	2,073
82	2,468	3,090	2,492	997	1,883	82	2,838	3,555	2,866	1,147	2,165
83	2,578	3,230	2,605	1,042	1,968	83	2,965	3,715	2,994	1,198	2,264
84	2,694	3,374	2,721	1,089	2,057	84	3,099	3,881	3,129	1,252	2,366
85	2,816	3,526	2,844	1,138	2,150	85	3,238	4,057	3,271	1,307	2,472
86	2,942	3,686	2,972	1,189	2,247	86	3,385	4,239	3,418	1,368	2,584
87	3,074	3,851	3,106	1,243	2,347	87	3,535	4,430	3,572	1,429	2,700
88	3,213	4,024	3,245	1,298	2,452	88	3,695	4,628	3,733	1,493	2,821
89	3,357	4,206	3,392	1,357	2,563	89	3,861	4,836	3,900	1,560	2,949
90	3,507	4,395	3,544	1,418	2,679	90	4,035	5,055	4,076	1,631	3,080
91	3,666	4,593	3,703	1,482	2,799	91	4,217	5,283	4,258	1,703	3,221
92	3,831	4,799	3,870	1,549	2,926	92	4,406	5,521	4,451	1,780	3,364
93	4,003	5,016	4,043	1,618	3,057	93	4,605	5,768	4,650	1,860	3,517
94	4,184	5,242	4,226	1,691	3,196	94	4,812	6,029	4,860	1,944	3,675
95	4,373	5,478	4,417	1,767	3,339	95	5,028	6,299	5,079	2,031	3,841
96	4,570	5,724	4,615	1,846	3,489	96	5,254	6,583	5,307	2,122	4,013
97	4,775	5,983	4,822	1,929	3,647	97	5,490	6,879	5,546	2,218	4,194
98	4,989	6,252	5,040	2,016	3,812	98	5,738	7,189	5,796	2,318	4,382
99	5,215	6,532	5,267	2,107	3,983	99	5,996	7,513	6,057	2,423	4,581

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY

NEVADA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 889-891

	Preferred						Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,539	1,800	1,555	622	1,151	65	1,770	2,069	1,787	715	1,325
66	1,539	1,800	1,555	622	1,151	66	1,770	2,069	1,787	715	1,325
67	1,539	1,800	1,555	622	1,151	67	1,770	2,069	1,787	715	1,325
68	1,539	1,849	1,555	622	1,160	68	1,770	2,126	1,787	715	1,333
69	1,546	1,905	1,561	624	1,174	69	1,778	2,190	1,797	719	1,349
70	1,566	1,962	1,581	633	1,195	70	1,802	2,256	1,819	728	1,375
71	1,614	2,021	1,630	651	1,231	71	1,855	2,324	1,874	750	1,417
72	1,669	2,091	1,686	675	1,273	72	1,921	2,405	1,939	776	1,465
73	1,728	2,165	1,745	699	1,318	73	1,986	2,489	2,007	803	1,515
74	1,789	2,241	1,806	723	1,365	74	2,055	2,575	2,076	830	1,569
75	1,860	2,330	1,879	751	1,419	75	2,139	2,679	2,159	865	1,632
76	1,933	2,422	1,954	782	1,476	76	2,223	2,786	2,247	899	1,697
77	2,011	2,519	2,031	813	1,534	77	2,312	2,898	2,337	935	1,764
78	2,092	2,620	2,113	845	1,598	78	2,406	3,013	2,429	972	1,836
79	2,175	2,726	2,197	880	1,661	79	2,503	3,134	2,527	1,010	1,909
80	2,262	2,833	2,286	914	1,726	80	2,601	3,260	2,627	1,052	1,985
81	2,364	2,961	2,388	956	1,804	81	2,718	3,405	2,747	1,099	2,075
82	2,471	3,094	2,495	997	1,886	82	2,842	3,559	2,870	1,148	2,169
83	2,581	3,234	2,607	1,042	1,971	83	2,968	3,718	2,998	1,199	2,265
84	2,697	3,378	2,724	1,090	2,060	84	3,102	3,885	3,133	1,253	2,369
85	2,819	3,531	2,846	1,138	2,152	85	3,242	4,062	3,274	1,310	2,474
86	2,946	3,689	2,975	1,190	2,249	86	3,388	4,244	3,422	1,369	2,587
87	3,077	3,856	3,109	1,244	2,350	87	3,540	4,435	3,576	1,431	2,703
88	3,216	4,030	3,250	1,299	2,457	88	3,699	4,633	3,736	1,495	2,825
89	3,362	4,210	3,395	1,359	2,567	89	3,865	4,842	3,904	1,561	2,952
90	3,513	4,400	3,548	1,419	2,681	90	4,039	5,060	4,081	1,632	3,086
91	3,671	4,598	3,706	1,483	2,803	91	4,222	5,289	4,264	1,706	3,223
92	3,835	4,806	3,873	1,549	2,929	92	4,411	5,527	4,455	1,783	3,368
93	4,008	5,022	4,049	1,619	3,061	93	4,611	5,776	4,656	1,862	3,519
94	4,188	5,247	4,231	1,693	3,199	94	4,816	6,035	4,866	1,946	3,679
95	4,377	5,484	4,422	1,770	3,343	95	5,034	6,307	5,085	2,034	3,845
96	4,573	5,731	4,620	1,848	3,494	96	5,260	6,589	5,314	2,125	4,018
97	4,781	5,989	4,829	1,931	3,651	97	5,497	6,888	5,552	2,221	4,199
98	4,996	6,258	5,046	2,018	3,815	98	5,745	7,197	5,803	2,322	4,387
99	5,219	6,540	5,272	2,110	3,988	99	6,003	7,522	6,063	2,426	4,586

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

NEVADA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 889-891

	Preferred						Standard					
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,366	1,598	1,380	552	1,022	65	1,571	1,837	1,587	635	1,176
66	1,366	1,598	1,380	552	1,022	66	1,571	1,837	1,587	635	1,176
67	1,366	1,598	1,380	552	1,022	67	1,571	1,837	1,587	635	1,176
68	1,366	1,642	1,380	552	1,030	68	1,571	1,888	1,587	635	1,184
69	1,373	1,691	1,386	554	1,042	69	1,579	1,945	1,595	638	1,198
70	1,391	1,742	1,404	562	1,061	70	1,600	2,003	1,615	646	1,221
71	1,433	1,795	1,447	578	1,093	71	1,647	2,063	1,663	666	1,258
72	1,482	1,856	1,497	599	1,131	72	1,705	2,136	1,721	689	1,301
73	1,534	1,922	1,549	620	1,170	73	1,763	2,210	1,782	713	1,345
74	1,588	1,989	1,604	642	1,212	74	1,825	2,287	1,843	737	1,393
75	1,651	2,069	1,668	667	1,260	75	1,899	2,379	1,917	768	1,449
76	1,717	2,151	1,735	694	1,310	76	1,974	2,474	1,995	798	1,507
77	1,785	2,236	1,803	722	1,362	77	2,053	2,573	2,075	830	1,567
78	1,857	2,327	1,876	751	1,418	78	2,137	2,675	2,157	863	1,630
79	1,931	2,421	1,950	781	1,474	79	2,222	2,783	2,244	897	1,695
80	2,008	2,516	2,029	811	1,532	80	2,309	2,895	2,332	934	1,762
81	2,099	2,629	2,120	848	1,602	81	2,413	3,023	2,439	976	1,842
82	2,194	2,747	2,215	885	1,675	82	2,523	3,160	2,548	1,019	1,926
83	2,291	2,871	2,314	925	1,750	83	2,635	3,301	2,662	1,065	2,011
84	2,395	2,999	2,419	968	1,829	84	2,754	3,449	2,782	1,112	2,103
85	2,503	3,135	2,527	1,011	1,910	85	2,879	3,606	2,907	1,163	2,196
86	2,615	3,276	2,641	1,056	1,997	86	3,008	3,768	3,038	1,215	2,297
87	2,732	3,424	2,761	1,105	2,086	87	3,143	3,938	3,175	1,270	2,400
88	2,856	3,578	2,885	1,153	2,181	88	3,284	4,114	3,317	1,327	2,508
89	2,985	3,738	3,014	1,207	2,279	89	3,431	4,299	3,467	1,386	2,621
90	3,119	3,906	3,150	1,260	2,381	90	3,586	4,493	3,623	1,449	2,740
91	3,259	4,082	3,291	1,317	2,489	91	3,749	4,696	3,786	1,514	2,861
92	3,405	4,267	3,439	1,376	2,600	92	3,916	4,907	3,956	1,583	2,991
93	3,559	4,458	3,595	1,437	2,718	93	4,094	5,128	4,133	1,653	3,125
94	3,718	4,659	3,756	1,503	2,841	94	4,276	5,358	4,321	1,728	3,266
95	3,886	4,869	3,926	1,571	2,968	95	4,470	5,599	4,514	1,806	3,413
96	4,060	5,088	4,102	1,641	3,102	96	4,670	5,850	4,718	1,887	3,567
97	4,245	5,317	4,287	1,715	3,241	97	4,880	6,115	4,930	1,972	3,728
98	4,436	5,557	4,480	1,792	3,387	98	5,101	6,390	5,152	2,062	3,895
99	4,634	5,806	4,681	1,873	3,541	99	5,330	6,679	5,383	2,154	4,072

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 attained 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 attained age and will change on your policy anniversary date.

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.