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.

ACE PROPERTY & CASUALTY INSURANCE COMPANY

OKLAHOMA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 730-731, 741

	Preferred				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
0-64	1,413	N/A	N/A	N/A	N/A
65	1,413	1,640	1,427	565	1,083
66	1,413	1,640	1,427	565	1,083
67	1,413	1,640	1,427	565	1,083
68	1,415	1,686	1,429	567	1,088
69	1,423	1,736	1,436	569	1,102
70	1,442	1,788	1,455	577	1,123
71	1,484	1,842	1,499	594	1,156
72	1,536	1,905	1,551	615	1,197
73	1,590	1,973	1,605	636	1,239
74	1,645	2,040	1,661	658	1,282
75	1,712	2,123	1,728	684	1,333
76	1,780	2,208	1,798	712	1,386
77	1,850	2,296	1,869	740	1,442
78	1,925	2,388	1,944	771	1,500
79	2,001	2,484	2,021	801	1,560
80	2,081	2,582	2,103	833	1,621
81	2,175	2,699	2,197	870	1,695
82	2,273	2,819	2,295	909	1,771
83	2,375	2,946	2,399	951	1,851
84	2,481	3,078	2,506	993	1,934
85	2,594	3,217	2,620	1,038	2,022
86	2,710	3,362	2,737	1,085	2,113
87	2,832	3,513	2,860	1,134	2,208
88	2,959	3,671	2,989	1,184	2,307
89	3,092	3,837	3,124	1,238	2,411
90	3,231	4,009	3,264	1,294	2,520
91	3,377	4,190	3,410	1,352	2,632
92	3,529	4,378	3,565	1,412	2,752
93	3,688	4,576	3,724	1,476	2,876
94	3,854	4,782	3,892	1,542	3,006
95	4,028	4,997	4,068	1,612	3,141
96	4,208	5,222	4,250	1,684	3,282
97	4,397	5,458	4,442	1,760	3,430
98	4,596	5,703	4,642	1,839	3,585
99	4,803	5,959	4,851	1,922	3,746

	Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
0-64	1,625	N/A	N/A	N/A	N/A
65	1,625	1,887	1,641	650	1,245
66	1,625	1,887	1,641	650	1,245
67	1,625	1,887	1,641	650	1,245
68	1,628	1,938	1,643	652	1,251
69	1,636	1,996	1,653	655	1,269
70	1,658	2,056	1,674	664	1,292
71	1,707	2,117	1,724	683	1,330
72	1,767	2,191	1,784	707	1,377
73	1,828	2,268	1,846	731	1,425
74	1,892	2,347	1,911	757	1,474
75	1,968	2,442	1,987	787	1,533
76	2,046	2,539	2,067	820	1,594
77	2,127	2,641	2,149	852	1,658
78	2,213	2,746	2,235	886	1,725
79	2,302	2,856	2,325	921	1,793
80	2,394	2,970	2,418	958	1,865
81	2,501	3,103	2,526	1,002	1,949
82	2,613	3,243	2,640	1,046	2,036
83	2,731	3,388	2,758	1,093	2,129
84	2,854	3,540	2,882	1,142	2,225
85	2,982	3,700	3,012	1,193	2,324
86	3,117	3,867	3,148	1,248	2,430
87	3,256	4,041	3,290	1,303	2,539
88	3,403	4,222	3,438	1,362	2,653
89	3,556	4,412	3,592	1,423	2,774
90	3,716	4,611	3,754	1,488	2,897
91	3,884	4,819	3,922	1,554	3,028
92	4,058	5,037	4,099	1,624	3,164
93	4,241	5,262	4,283	1,697	3,307
94	4,432	5,500	4,476	1,773	3,456
95	4,632	5,747	4,678	1,853	3,612
96	4,839	6,005	4,888	1,936	3,774
97	5,057	6,275	5,108	2,024	3,945
98	5,285	6,558	5,338	2,114	4,122
99	5,523	6,854	5,579	2,210	4,308

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

OKLAHOMA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 730-731, 741

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,300	N/A	N/A	N/A	N/A
65	1,300	1,509	1,313	520	996
66	1,300	1,509	1,313	520	996
67	1,300	1,509	1,313	520	996
68	1,302	1,551	1,315	521	1,001
69	1,309	1,597	1,321	523	1,014
70	1,326	1,645	1,339	531	1,033
71	1,365	1,694	1,379	546	1,064
72	1,413	1,753	1,427	565	1,101
73	1,463	1,815	1,477	586	1,140
74	1,514	1,877	1,528	606	1,180
75	1,575	1,953	1,590	630	1,227
76	1,637	2,031	1,654	655	1,275
77	1,702	2,113	1,719	681	1,327
78	1,771	2,197	1,788	709	1,380
79	1,841	2,285	1,860	737	1,435
80	1,915	2,376	1,935	766	1,492
81	2,001	2,483	2,021	801	1,560
82	2,091	2,594	2,112	836	1,629
83	2,185	2,711	2,207	875	1,703
84	2,283	2,832	2,306	914	1,780
85	2,386	2,959	2,410	955	1,860
86	2,493	3,093	2,518	998	1,944
87	2,605	3,232	2,631	1,043	2,031
88	2,722	3,378	2,750	1,089	2,122
89	2,845	3,530	2,874	1,139	2,218
90	2,972	3,688	3,003	1,190	2,318
91	3,107	3,855	3,138	1,244	2,422
92	3,247	4,028	3,280	1,299	2,532
93	3,393	4,210	3,426	1,358	2,646
94	3,545	4,399	3,581	1,419	2,765
95	3,706	4,597	3,742	1,483	2,890
96	3,872	4,804	3,910	1,549	3,020
97	4,046	5,021	4,086	1,619	3,156
98	4,228	5,247	4,271	1,692	3,298
99	4,418	5,482	4,463	1,768	3,446

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,495	N/A	N/A	N/A	N/A
65	1,495	1,736	1,510	598	1,145
66	1,495	1,736	1,510	598	1,145
67	1,495	1,736	1,510	598	1,145
68	1,497	1,783	1,512	600	1,151
69	1,505	1,836	1,520	603	1,167
70	1,525	1,892	1,540	610	1,188
71	1,571	1,948	1,586	629	1,224
72	1,626	2,016	1,641	651	1,267
73	1,682	2,087	1,698	673	1,311
74	1,741	2,159	1,758	697	1,356
75	1,810	2,247	1,828	724	1,410
76	1,883	2,336	1,902	754	1,467
77	1,957	2,429	1,977	784	1,525
78	2,036	2,526	2,057	815	1,587
79	2,117	2,627	2,139	848	1,650
80	2,202	2,733	2,225	881	1,716
81	2,301	2,855	2,324	921	1,793
82	2,404	2,983	2,429	963	1,873
83	2,513	3,117	2,538	1,006	1,959
84	2,626	3,257	2,652	1,051	2,047
85	2,743	3,404	2,771	1,097	2,138
86	2,868	3,557	2,896	1,148	2,236
87	2,996	3,718	3,026	1,199	2,336
88	3,131	3,885	3,163	1,253	2,441
89	3,272	4,059	3,305	1,309	2,552
90	3,419	4,242	3,453	1,369	2,666
91	3,573	4,434	3,608	1,429	2,786
92	3,734	4,634	3,771	1,495	2,911
93	3,902	4,841	3,940	1,561	3,043
94	4,077	5,060	4,118	1,631	3,179
95	4,261	5,287	4,304	1,705	3,323
96	4,452	5,525	4,497	1,782	3,472
97	4,652	5,773	4,700	1,862	3,629
98	4,862	6,034	4,911	1,945	3,792
99	5,081	6,305	5,132	2,033	3,963

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

OKLAHOMA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 730-731, 741

	Preferred				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
0-64	1,256	N/A	N/A	N/A	N/A
65	1,256	1,458	1,269	501	962
66	1,256	1,458	1,269	501	962
67	1,256	1,458	1,269	501	962
68	1,258	1,498	1,272	503	968
69	1,264	1,542	1,277	505	980
70	1,281	1,589	1,294	513	998
71	1,320	1,637	1,332	527	1,028
72	1,365	1,693	1,379	547	1,064
73	1,413	1,753	1,427	566	1,101
74	1,463	1,815	1,477	586	1,140
75	1,520	1,888	1,536	608	1,185
76	1,581	1,962	1,598	633	1,232
77	1,644	2,040	1,661	658	1,281
78	1,710	2,123	1,728	684	1,333
79	1,779	2,208	1,797	712	1,386
80	1,850	2,295	1,869	740	1,441
81	1,933	2,398	1,953	774	1,506
82	2,020	2,506	2,040	808	1,575
83	2,111	2,619	2,132	844	1,645
84	2,206	2,736	2,228	883	1,720
85	2,306	2,860	2,328	922	1,797
86	2,409	2,988	2,433	964	1,878
87	2,517	3,123	2,543	1,008	1,962
88	2,630	3,264	2,658	1,052	2,051
89	2,749	3,410	2,776	1,100	2,143
90	2,873	3,564	2,901	1,149	2,239
91	3,002	3,724	3,031	1,201	2,340
92	3,136	3,893	3,168	1,255	2,446
93	3,278	4,067	3,311	1,311	2,556
94	3,425	4,250	3,460	1,371	2,672
95	3,579	4,442	3,616	1,433	2,791
96	3,740	4,642	3,778	1,497	2,917
97	3,909	4,851	3,949	1,564	3,048
98	4,086	5,069	4,127	1,635	3,186
99	4,268	5,297	4,311	1,709	3,330

	Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
0-64	1,445	N/A	N/A	N/A	N/A
65	1,445	1,676	1,460	577	1,107
66	1,445	1,676	1,460	577	1,107
67	1,445	1,676	1,460	577	1,107
68	1,447	1,722	1,462	579	1,113
69	1,454	1,774	1,469	582	1,127
70	1,473	1,827	1,488	590	1,148
71	1,517	1,882	1,532	607	1,182
72	1,571	1,948	1,586	628	1,223
73	1,624	2,016	1,641	650	1,266
74	1,681	2,086	1,698	673	1,310
75	1,749	2,170	1,766	700	1,362
76	1,819	2,257	1,838	728	1,418
77	1,891	2,347	1,911	757	1,474
78	1,968	2,441	1,987	787	1,533
79	2,046	2,539	2,066	818	1,594
80	2,127	2,641	2,148	852	1,658
81	2,223	2,758	2,246	890	1,733
82	2,324	2,883	2,347	930	1,811
83	2,428	3,012	2,452	971	1,892
84	2,537	3,147	2,562	1,015	1,978
85	2,651	3,290	2,678	1,061	2,066
86	2,770	3,437	2,798	1,109	2,160
87	2,895	3,592	2,924	1,159	2,257
88	3,025	3,752	3,056	1,211	2,359
89	3,161	3,922	3,193	1,265	2,465
90	3,303	4,099	3,337	1,322	2,576
91	3,452	4,284	3,487	1,381	2,692
92	3,607	4,476	3,644	1,444	2,812
93	3,771	4,678	3,807	1,508	2,939
94	3,939	4,888	3,980	1,577	3,072
95	4,117	5,108	4,158	1,647	3,210
96	4,302	5,337	4,345	1,721	3,355
97	4,495	5,579	4,540	1,799	3,506
98	4,698	5,829	4,745	1,880	3,664
99	4,909	6,092	4,958	1,965	3,829

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

OKLAHOMA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 730-731, 741

	Preferred				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
0-64	1,155	N/A	N/A	N/A	N/A
65	1,155	1,341	1,168	461	885
66	1,155	1,341	1,168	461	885
67	1,155	1,341	1,168	461	885
68	1,157	1,378	1,170	463	891
69	1,163	1,419	1,175	465	901
70	1,179	1,462	1,190	472	919
71	1,214	1,506	1,226	485	945
72	1,256	1,558	1,268	503	979
73	1,300	1,613	1,313	520	1,013
74	1,346	1,670	1,359	539	1,049
75	1,399	1,737	1,413	560	1,090
76	1,455	1,805	1,470	583	1,134
77	1,513	1,877	1,528	606	1,179
78	1,574	1,953	1,590	630	1,227
79	1,636	2,031	1,653	655	1,275
80	1,702	2,112	1,719	681	1,326
81	1,778	2,206	1,797	712	1,385
82	1,859	2,306	1,877	743	1,449
83	1,942	2,409	1,961	777	1,514
84	2,030	2,517	2,050	812	1,583
85	2,121	2,631	2,142	849	1,653
86	2,216	2,749	2,238	887	1,728
87	2,316	2,873	2,340	927	1,805
88	2,420	3,002	2,445	968	1,887
89	2,529	3,137	2,554	1,012	1,972
90	2,643	3,279	2,669	1,057	2,060
91	2,762	3,426	2,789	1,105	2,153
92	2,885	3,581	2,914	1,155	2,250
93	3,016	3,742	3,046	1,207	2,352
94	3,151	3,910	3,183	1,261	2,458
95	3,293	4,086	3,327	1,318	2,568
96	3,441	4,270	3,476	1,377	2,684
97	3,596	4,463	3,633	1,439	2,804
98	3,759	4,663	3,796	1,504	2,931
99	3,927	4,873	3,966	1,572	3,064

	Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
0-64	1,329	N/A	N/A	N/A	N/A
65	1,329	1,542	1,343	531	1,018
66	1,329	1,542	1,343	531	1,018
67	1,329	1,542	1,343	531	1,018
68	1,331	1,584	1,345	533	1,024
69	1,338	1,632	1,351	536	1,037
70	1,355	1,681	1,369	543	1,056
71	1,396	1,732	1,409	559	1,088
72	1,445	1,792	1,459	578	1,125
73	1,494	1,854	1,510	598	1,164
74	1,547	1,919	1,562	619	1,206
75	1,609	1,997	1,625	644	1,253
76	1,673	2,076	1,691	670	1,304
77	1,740	2,159	1,758	697	1,356
78	1,810	2,246	1,828	724	1,410
79	1,883	2,336	1,901	753	1,467
80	1,957	2,429	1,976	784	1,525
81	2,045	2,537	2,066	819	1,594
82	2,138	2,652	2,159	855	1,666
83	2,233	2,771	2,256	894	1,740
84	2,334	2,895	2,357	934	1,820
85	2,439	3,026	2,463	976	1,901
86	2,548	3,162	2,574	1,020	1,987
87	2,663	3,305	2,690	1,066	2,076
88	2,783	3,452	2,811	1,114	2,170
89	2,908	3,608	2,938	1,163	2,268
90	3,039	3,771	3,070	1,216	2,370
91	3,176	3,941	3,208	1,271	2,476
92	3,318	4,118	3,352	1,328	2,587
93	3,469	4,304	3,503	1,387	2,704
94	3,623	4,497	3,661	1,451	2,826
95	3,788	4,700	3,825	1,516	2,954
96	3,958	4,910	3,997	1,584	3,087
97	4,135	5,132	4,177	1,655	3,225
98	4,322	5,363	4,365	1,730	3,371
99	4,516	5,605	4,561	1,807	3,523

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. If we do not return premium within 30 days from the date of cancellation, we will pay interest on the proceeds in accordance with Oklahoma law.

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.