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

KANSAS Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 660-662, 672

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,585	1,837	1,601	635	1,213
65	1,585	1,837	1,601	635	1,213
66	1,585	1,837	1,601	635	1,213
67	1,585	1,837	1,601	635	1,213
68	1,585	1,888	1,601	635	1,218
69	1,593	1,944	1,609	637	1,235
70	1,615	2,002	1,630	646	1,258
71	1,662	2,063	1,679	665	1,295
72	1,720	2,134	1,737	688	1,341
73	1,780	2,210	1,798	713	1,387
74	1,843	2,285	1,860	737	1,436
75	1,917	2,377	1,936	766	1,493
76	1,993	2,473	2,013	798	1,553
77	2,072	2,572	2,093	829	1,616
78	2,156	2,674	2,177	863	1,680
79	2,241	2,782	2,264	897	1,747
80	2,331	2,892	2,356	933	1,816
81	2,435	3,023	2,460	975	1,899
82	2,546	3,158	2,571	1,018	1,984
83	2,660	3,300	2,687	1,065	2,073
84	2,779	3,448	2,807	1,112	2,167
85	2,905	3,603	2,934	1,162	2,264
86	3,035	3,766	3,066	1,215	2,367
87	3,172	3,935	3,203	1,270	2,473
88	3,314	4,112	3,348	1,326	2,584
89	3,463	4,297	3,499	1,386	2,700
90	3,619	4,490	3,656	1,449	2,822
91	3,782	4,693	3,820	1,514	2,948
92	3,953	4,904	3,993	1,582	3,082
93	4,130	5,125	4,171	1,653	3,221
94	4,316	5,356	4,359	1,727	3,366
95	4,511	5,597	4,556	1,805	3,518
96	4,713	5,848	4,760	1,886	3,676
97	4,925	6,113	4,974	1,971	3,842
98	5,147	6,388	5,199	2,059	4,015
99	5,379	6,674	5,433	2,153	4,196

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,823	2,113	1,840	730	1,394
65	1,823	2,113	1,840	730	1,394
66	1,823	2,113	1,840	730	1,394
67	1,823	2,113	1,840	730	1,394
68	1,823	2,170	1,840	730	1,401
69	1,832	2,235	1,851	734	1,421
70	1,857	2,303	1,875	743	1,447
71	1,912	2,372	1,931	765	1,490
72	1,979	2,454	1,998	792	1,542
73	2,047	2,540	2,067	819	1,596
74	2,119	2,629	2,140	848	1,651
75	2,204	2,735	2,225	882	1,717
76	2,292	2,843	2,316	918	1,786
77	2,383	2,957	2,407	954	1,857
78	2,479	3,075	2,504	992	1,932
79	2,578	3,199	2,604	1,032	2,008
80	2,681	3,327	2,708	1,073	2,088
81	2,801	3,476	2,829	1,122	2,183
82	2,927	3,632	2,956	1,172	2,281
83	3,059	3,795	3,089	1,224	2,384
84	3,196	3,965	3,228	1,279	2,492
85	3,340	4,144	3,374	1,336	2,603
86	3,492	4,331	3,526	1,398	2,722
87	3,647	4,526	3,684	1,459	2,843
88	3,811	4,729	3,850	1,526	2,971
89	3,983	4,941	4,023	1,593	3,107
90	4,162	5,165	4,204	1,667	3,245
91	4,350	5,398	4,392	1,740	3,392
92	4,545	5,641	4,591	1,819	3,543
93	4,750	5,894	4,797	1,901	3,704
94	4,964	6,159	5,013	1,986	3,871
95	5,187	6,437	5,239	2,076	4,045
96	5,420	6,726	5,474	2,169	4,227
97	5,664	7,028	5,721	2,267	4,418
98	5,919	7,345	5,979	2,368	4,616
99	6,186	7,676	6,248	2,475	4,825

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

KANSAS Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 660-662, 672

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,543	1,788	1,558	618	1,180
65	1,543	1,788	1,558	618	1,180
66	1,543	1,788	1,558	618	1,180
67	1,543	1,788	1,558	618	1,180
68	1,543	1,838	1,558	618	1,186
69	1,551	1,892	1,566	620	1,202
70	1,571	1,949	1,586	629	1,224
71	1,617	2,008	1,634	647	1,261
72	1,674	2,077	1,690	670	1,305
73	1,733	2,150	1,750	694	1,350
74	1,793	2,224	1,811	718	1,398
75	1,866	2,314	1,884	746	1,453
76	1,940	2,407	1,959	777	1,511
77	2,017	2,503	2,037	807	1,572
78	2,098	2,603	2,118	840	1,635
79	2,181	2,707	2,203	873	1,700
80	2,268	2,815	2,292	908	1,767
81	2,370	2,942	2,394	949	1,848
82	2,478	3,073	2,502	991	1,931
83	2,589	3,211	2,615	1,036	2,018
84	2,704	3,355	2,732	1,083	2,108
85	2,827	3,506	2,856	1,131	2,204
86	2,954	3,665	2,984	1,182	2,303
87	3,087	3,829	3,118	1,236	2,407
88	3,225	4,002	3,258	1,290	2,514
89	3,371	4,182	3,405	1,349	2,628
90	3,522	4,370	3,558	1,410	2,747
91	3,681	4,567	3,717	1,474	2,869
92	3,847	4,772	3,886	1,539	3,000
93	4,019	4,988	4,060	1,609	3,134
94	4,200	5,212	4,243	1,681	3,276
95	4,390	5,447	4,434	1,757	3,423
96	4,587	5,692	4,633	1,835	3,578
97	4,793	5,949	4,841	1,918	3,739
98	5,009	6,217	5,060	2,004	3,908
99	5,235	6,496	5,288	2,095	4,083

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,774	2,056	1,791	711	1,357
65	1,774	2,056	1,791	711	1,357
66	1,774	2,056	1,791	711	1,357
67	1,774	2,056	1,791	711	1,357
68	1,774	2,112	1,791	711	1,364
69	1,783	2,175	1,801	714	1,383
70	1,807	2,241	1,824	723	1,408
71	1,861	2,308	1,879	745	1,450
72	1,926	2,388	1,945	771	1,501
73	1,993	2,472	2,012	797	1,553
74	2,062	2,559	2,083	825	1,606
75	2,145	2,662	2,165	858	1,671
76	2,231	2,767	2,254	893	1,738
77	2,319	2,878	2,343	928	1,807
78	2,413	2,993	2,437	966	1,881
79	2,509	3,113	2,534	1,004	1,954
80	2,609	3,238	2,636	1,044	2,033
81	2,726	3,383	2,754	1,092	2,124
82	2,849	3,535	2,877	1,140	2,220
83	2,977	3,693	3,007	1,191	2,320
84	3,111	3,859	3,142	1,245	2,425
85	3,250	4,033	3,284	1,300	2,534
86	3,398	4,215	3,431	1,360	2,649
87	3,549	4,405	3,586	1,420	2,767
88	3,709	4,602	3,747	1,485	2,892
89	3,876	4,809	3,915	1,551	3,023
90	4,050	5,026	4,092	1,622	3,158
91	4,234	5,253	4,275	1,694	3,301
92	4,423	5,490	4,468	1,771	3,448
93	4,623	5,736	4,668	1,850	3,605
94	4,831	5,994	4,879	1,933	3,767
95	5,048	6,264	5,099	2,020	3,937
96	5,275	6,545	5,328	2,111	4,114
97	5,512	6,840	5,568	2,206	4,300
98	5,760	7,148	5,819	2,305	4,492
99	6,020	7,470	6,081	2,409	4,695

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

KANSAS Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 660-662, 672

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,409	1,633	1,424	564	1,077
65	1,409	1,633	1,424	564	1,077
66	1,409	1,633	1,424	564	1,077
67	1,409	1,633	1,424	564	1,077
68	1,409	1,677	1,424	564	1,084
69	1,416	1,727	1,430	566	1,097
70	1,435	1,780	1,449	574	1,118
71	1,478	1,833	1,492	591	1,151
72	1,529	1,896	1,544	613	1,192
73	1,583	1,964	1,598	634	1,234
74	1,638	2,033	1,655	656	1,277
75	1,703	2,114	1,720	681	1,327
76	1,771	2,198	1,790	709	1,380
77	1,842	2,285	1,860	737	1,435
78	1,916	2,377	1,936	766	1,493
79	1,992	2,473	2,012	798	1,553
80	2,072	2,571	2,093	829	1,614
81	2,165	2,686	2,187	867	1,687
82	2,263	2,807	2,285	905	1,764
83	2,364	2,933	2,387	946	1,843
84	2,471	3,065	2,495	989	1,927
85	2,582	3,203	2,607	1,033	2,013
86	2,698	3,346	2,725	1,080	2,104
87	2,819	3,498	2,848	1,129	2,198
88	2,946	3,655	2,976	1,179	2,297
89	3,079	3,819	3,109	1,232	2,401
90	3,218	3,992	3,249	1,287	2,508
91	3,362	4,171	3,395	1,345	2,621
92	3,513	4,360	3,548	1,406	2,740
93	3,671	4,556	3,708	1,469	2,863
94	3,836	4,761	3,875	1,535	2,992
95	4,009	4,975	4,050	1,605	3,126
96	4,189	5,199	4,231	1,676	3,267
97	4,378	5,433	4,423	1,752	3,414
98	4,576	5,677	4,622	1,831	3,568
99	4,780	5,932	4,829	1,914	3,730

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,621	1,878	1,637	649	1,239
65	1,621	1,878	1,637	649	1,239
66	1,621	1,878	1,637	649	1,239
67	1,621	1,878	1,637	649	1,239
68	1,621	1,929	1,637	649	1,246
69	1,629	1,987	1,645	652	1,263
70	1,650	2,047	1,666	660	1,286
71	1,699	2,108	1,716	680	1,324
72	1,759	2,182	1,776	704	1,370
73	1,819	2,257	1,838	728	1,418
74	1,883	2,337	1,902	754	1,468
75	1,959	2,431	1,978	784	1,526
76	2,037	2,528	2,058	815	1,588
77	2,118	2,629	2,140	848	1,651
78	2,204	2,734	2,225	882	1,717
79	2,292	2,843	2,314	917	1,786
80	2,383	2,957	2,406	954	1,857
81	2,490	3,089	2,515	997	1,941
82	2,602	3,229	2,628	1,041	2,028
83	2,719	3,373	2,746	1,088	2,119
84	2,841	3,525	2,869	1,137	2,215
85	2,969	3,684	2,999	1,188	2,314
86	3,102	3,850	3,134	1,242	2,419
87	3,242	4,023	3,275	1,298	2,528
88	3,388	4,203	3,422	1,356	2,642
89	3,540	4,392	3,576	1,416	2,761
90	3,700	4,590	3,737	1,480	2,885
91	3,867	4,798	3,905	1,547	3,015
92	4,040	5,013	4,081	1,617	3,150
93	4,223	5,239	4,264	1,689	3,292
94	4,411	5,475	4,457	1,766	3,441
95	4,611	5,721	4,657	1,845	3,596
96	4,818	5,978	4,866	1,928	3,758
97	5,034	6,248	5,085	2,015	3,927
98	5,261	6,529	5,314	2,106	4,104
99	5,498	6,823	5,553	2,200	4,289

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY

KANSAS Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 660-662, 672

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,371	1,589	1,386	549	1,049
65	1,371	1,589	1,386	549	1,049
66	1,371	1,589	1,386	549	1,049
67	1,371	1,589	1,386	549	1,049
68	1,371	1,632	1,386	549	1,055
69	1,378	1,681	1,392	551	1,068
70	1,396	1,732	1,410	559	1,088
71	1,439	1,784	1,452	575	1,120
72	1,488	1,846	1,503	596	1,160
73	1,540	1,911	1,555	617	1,200
74	1,594	1,978	1,610	638	1,242
75	1,657	2,057	1,674	663	1,291
76	1,724	2,139	1,742	690	1,343
77	1,792	2,224	1,811	718	1,397
78	1,864	2,314	1,884	746	1,453
79	1,939	2,407	1,958	777	1,511
80	2,017	2,502	2,037	807	1,571
81	2,107	2,614	2,129	843	1,641
82	2,202	2,732	2,224	881	1,716
83	2,300	2,854	2,323	920	1,793
84	2,405	2,983	2,429	962	1,875
85	2,513	3,117	2,537	1,006	1,959
86	2,625	3,257	2,652	1,051	2,047
87	2,743	3,404	2,772	1,098	2,139
88	2,867	3,557	2,897	1,147	2,235
89	2,996	3,717	3,026	1,199	2,336
90	3,131	3,885	3,162	1,253	2,441
91	3,272	4,059	3,304	1,309	2,551
92	3,419	4,243	3,453	1,368	2,666
93	3,573	4,434	3,609	1,429	2,786
94	3,733	4,633	3,771	1,494	2,912
95	3,902	4,842	3,942	1,562	3,043
96	4,077	5,059	4,118	1,631	3,180
97	4,261	5,287	4,304	1,705	3,323
98	4,453	5,525	4,498	1,782	3,472
99	4,652	5,773	4,699	1,863	3,630

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,577	1,827	1,593	631	1,206
65	1,577	1,827	1,593	631	1,206
66	1,577	1,827	1,593	631	1,206
67	1,577	1,827	1,593	631	1,206
68	1,577	1,877	1,593	631	1,213
69	1,585	1,934	1,601	635	1,229
70	1,606	1,992	1,622	643	1,251
71	1,654	2,052	1,670	662	1,289
72	1,712	2,123	1,728	685	1,333
73	1,771	2,197	1,789	709	1,380
74	1,832	2,274	1,851	733	1,428
75	1,907	2,366	1,925	763	1,485
76	1,982	2,460	2,003	794	1,545
77	2,061	2,559	2,083	825	1,606
78	2,145	2,661	2,165	858	1,671
79	2,231	2,767	2,252	892	1,738
80	2,319	2,878	2,342	928	1,807
81	2,423	3,006	2,448	970	1,889
82	2,533	3,142	2,558	1,013	1,974
83	2,646	3,283	2,672	1,059	2,062
84	2,765	3,430	2,793	1,106	2,156
85	2,890	3,586	2,918	1,156	2,252
86	3,019	3,747	3,050	1,208	2,354
87	3,155	3,915	3,187	1,263	2,460
88	3,297	4,090	3,330	1,320	2,571
89	3,445	4,275	3,480	1,378	2,687
90	3,601	4,468	3,637	1,441	2,808
91	3,763	4,669	3,801	1,505	2,934
92	3,931	4,879	3,971	1,573	3,065
93	4,110	5,099	4,150	1,644	3,204
94	4,293	5,328	4,338	1,719	3,349
95	4,488	5,568	4,532	1,796	3,499
96	4,689	5,818	4,736	1,876	3,657
97	4,900	6,081	4,949	1,961	3,821
98	5,120	6,354	5,172	2,050	3,994
99	5,351	6,641	5,404	2,141	4,174

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.

RENEWAL CONDITIONS

You may renew this policy as long as you live by paying the premium on time. We cannot cancel or refuse to renew your policy, or place any restrictions on it, other than for non-payment or for fraudulent misstatements made by you in your application for the policy.

CANCELLATION BY INSURED

You may cancel this policy at any time by written notice delivered or mailed to us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. Claims will not be paid for dates of service after the date of cancellation except as provided for under the Extension of Benefits Provision.

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.

The following information is to be filled in by an agent or employee of the company who assumes responsibility for completing this outline of coverage:

The premium amount for the policy is: $ _____

The premium mode is (Circle one): Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly ☐

Name and Address of Insurance Agent or the Employee of the Company Assuming Responsibility for Completing This Outline of Coverage:

_____

_____

_____

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.