

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					

¹Plans 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.

²Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

³Plan 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.

MICHIGAN Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 480, 482, 483, 485

Attained Age	Preferred					Attained Age	Standard				
	HD						HD				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
65	1,672	1,938	1,688	669	1,272	65	1,923	2,228	1,941	769	1,463
66	1,672	1,938	1,688	669	1,272	66	1,923	2,228	1,941	769	1,463
67	1,672	1,938	1,688	669	1,272	67	1,923	2,228	1,941	769	1,463
68	1,672	1,997	1,688	669	1,285	68	1,923	2,295	1,941	769	1,478
69	1,681	2,055	1,698	673	1,310	69	1,934	2,364	1,952	774	1,506
70	1,698	2,117	1,714	679	1,337	70	1,952	2,435	1,971	781	1,537
71	1,746	2,181	1,764	700	1,379	71	2,009	2,509	2,029	804	1,584
72	1,807	2,257	1,827	723	1,425	72	2,080	2,597	2,101	832	1,638
73	1,871	2,336	1,891	750	1,475	73	2,151	2,687	2,173	863	1,696
74	1,937	2,417	1,957	775	1,527	74	2,228	2,780	2,251	892	1,756
75	2,016	2,514	2,036	806	1,588	75	2,317	2,891	2,340	927	1,828
76	2,095	2,614	2,118	840	1,652	76	2,410	3,007	2,435	965	1,898
77	2,181	2,718	2,201	872	1,718	77	2,507	3,126	2,533	1,003	1,976
78	2,267	2,827	2,290	908	1,786	78	2,606	3,250	2,634	1,044	2,054
79	2,357	2,941	2,381	943	1,857	79	2,710	3,380	2,738	1,084	2,134
80	2,452	3,058	2,477	982	1,932	80	2,821	3,517	2,848	1,128	2,222
81	2,563	3,195	2,587	1,026	2,019	81	2,946	3,675	2,975	1,179	2,323
82	2,677	3,339	2,705	1,072	2,110	82	3,079	3,840	3,109	1,231	2,426
83	2,799	3,489	2,826	1,119	2,205	83	3,217	4,012	3,251	1,287	2,537
84	2,924	3,646	2,952	1,169	2,303	84	3,362	4,193	3,396	1,346	2,649
85	3,055	3,809	3,086	1,222	2,408	85	3,514	4,379	3,549	1,404	2,771
86	3,192	3,980	3,225	1,276	2,516	86	3,672	4,578	3,708	1,469	2,894
87	3,335	4,160	3,370	1,336	2,628	87	3,837	4,784	3,875	1,536	3,024
88	3,486	4,346	3,520	1,394	2,748	88	4,010	4,999	4,049	1,605	3,159
89	3,643	4,542	3,679	1,458	2,870	89	4,188	5,223	4,232	1,676	3,301
90	3,806	4,746	3,845	1,523	2,999	90	4,378	5,459	4,421	1,752	3,450
91	3,978	4,958	4,017	1,593	3,134	91	4,575	5,704	4,620	1,831	3,604
92	4,156	5,182	4,199	1,663	3,276	92	4,779	5,960	4,828	1,913	3,766
93	4,344	5,416	4,387	1,738	3,422	93	4,994	6,229	5,044	1,999	3,935
94	4,538	5,661	4,585	1,817	3,576	94	5,219	6,510	5,271	2,089	4,113
95	4,744	5,916	4,790	1,897	3,737	95	5,455	6,802	5,509	2,182	4,298
96	4,956	6,181	5,005	1,982	3,906	96	5,699	7,110	5,758	2,280	4,489
97	5,178	6,460	5,231	2,072	4,080	97	5,956	7,429	6,016	2,385	4,692
98	5,413	6,751	5,467	2,166	4,264	98	6,224	7,763	6,287	2,491	4,904
99	5,656	7,055	5,714	2,263	4,456	99	6,504	8,112	6,571	2,602	5,125

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

MICHIGAN Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 481, 484, 486-489

Attained Age	Preferred					Attained Age	Standard				
	HD						HD				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
65	1,572	1,822	1,587	629	1,195	65	1,808	2,095	1,825	723	1,375
66	1,572	1,822	1,587	629	1,195	66	1,808	2,095	1,825	723	1,375
67	1,572	1,822	1,587	629	1,195	67	1,808	2,095	1,825	723	1,375
68	1,572	1,877	1,587	629	1,208	68	1,808	2,158	1,825	723	1,390
69	1,580	1,932	1,596	633	1,232	69	1,818	2,223	1,835	728	1,416
70	1,596	1,991	1,611	638	1,257	70	1,835	2,289	1,853	734	1,445
71	1,641	2,050	1,659	658	1,296	71	1,888	2,359	1,908	756	1,489
72	1,699	2,122	1,717	680	1,340	72	1,955	2,441	1,975	782	1,540
73	1,759	2,196	1,778	705	1,387	73	2,022	2,526	2,043	811	1,595
74	1,821	2,272	1,840	729	1,436	74	2,095	2,614	2,116	839	1,651
75	1,895	2,364	1,914	757	1,493	75	2,178	2,718	2,200	872	1,718
76	1,969	2,457	1,991	789	1,554	76	2,266	2,827	2,289	907	1,785
77	2,050	2,556	2,070	820	1,615	77	2,357	2,939	2,382	943	1,858
78	2,131	2,658	2,153	853	1,679	78	2,450	3,056	2,476	982	1,931
79	2,216	2,765	2,238	887	1,746	79	2,548	3,178	2,574	1,019	2,007
80	2,305	2,875	2,328	923	1,817	80	2,652	3,306	2,677	1,060	2,089
81	2,409	3,004	2,432	964	1,898	81	2,770	3,455	2,797	1,109	2,184
82	2,517	3,139	2,543	1,008	1,984	82	2,894	3,610	2,923	1,158	2,281
83	2,631	3,280	2,657	1,052	2,073	83	3,025	3,772	3,056	1,210	2,385
84	2,749	3,427	2,775	1,099	2,166	84	3,161	3,942	3,192	1,265	2,490
85	2,872	3,581	2,901	1,149	2,264	85	3,303	4,117	3,337	1,320	2,605
86	3,001	3,742	3,032	1,200	2,366	86	3,452	4,304	3,486	1,381	2,720
87	3,136	3,911	3,168	1,256	2,471	87	3,607	4,498	3,643	1,444	2,843
88	3,278	4,086	3,309	1,311	2,583	88	3,770	4,700	3,807	1,509	2,970
89	3,425	4,271	3,459	1,371	2,699	89	3,937	4,910	3,979	1,575	3,104
90	3,578	4,462	3,615	1,432	2,820	90	4,116	5,132	4,157	1,647	3,243
91	3,740	4,662	3,777	1,497	2,947	91	4,301	5,363	4,344	1,722	3,389
92	3,907	4,872	3,948	1,564	3,080	92	4,493	5,603	4,539	1,798	3,541
93	4,084	5,092	4,125	1,634	3,217	93	4,695	5,856	4,742	1,880	3,700
94	4,267	5,322	4,310	1,708	3,362	94	4,906	6,120	4,956	1,964	3,867
95	4,461	5,562	4,503	1,783	3,513	95	5,128	6,395	5,179	2,051	4,041
96	4,659	5,812	4,705	1,864	3,672	96	5,358	6,684	5,413	2,144	4,220
97	4,868	6,073	4,918	1,948	3,836	97	5,599	6,984	5,656	2,242	4,411
98	5,089	6,347	5,140	2,036	4,009	98	5,851	7,299	5,911	2,342	4,610
99	5,318	6,633	5,372	2,128	4,189	99	6,115	7,627	6,178	2,446	4,819

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

MICHIGAN Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 480-489

Attained Age	Preferred					Attained Age	Standard				
	HD						HD				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
65	1,415	1,640	1,428	566	1,076	65	1,627	1,885	1,642	651	1,238
66	1,415	1,640	1,428	566	1,076	66	1,627	1,885	1,642	651	1,238
67	1,415	1,640	1,428	566	1,076	67	1,627	1,885	1,642	651	1,238
68	1,415	1,690	1,428	566	1,087	68	1,627	1,942	1,642	651	1,251
69	1,422	1,739	1,437	569	1,109	69	1,636	2,001	1,652	655	1,275
70	1,437	1,792	1,450	575	1,132	70	1,652	2,060	1,667	661	1,300
71	1,477	1,845	1,493	592	1,167	71	1,700	2,123	1,717	681	1,341
72	1,529	1,910	1,546	612	1,206	72	1,760	2,197	1,778	704	1,386
73	1,583	1,977	1,600	634	1,248	73	1,820	2,273	1,839	730	1,435
74	1,639	2,045	1,656	656	1,292	74	1,886	2,353	1,904	755	1,486
75	1,706	2,127	1,722	682	1,344	75	1,960	2,446	1,980	785	1,546
76	1,772	2,212	1,792	710	1,398	76	2,039	2,544	2,060	816	1,606
77	1,845	2,300	1,863	738	1,454	77	2,122	2,645	2,143	848	1,672
78	1,918	2,392	1,938	768	1,511	78	2,205	2,750	2,229	883	1,738
79	1,995	2,489	2,015	798	1,571	79	2,293	2,860	2,317	917	1,806
80	2,075	2,587	2,096	831	1,635	80	2,387	2,976	2,410	954	1,880
81	2,168	2,704	2,189	868	1,708	81	2,493	3,109	2,518	998	1,966
82	2,265	2,825	2,289	907	1,785	82	2,605	3,249	2,631	1,042	2,053
83	2,368	2,952	2,391	947	1,866	83	2,722	3,395	2,751	1,089	2,147
84	2,474	3,085	2,498	989	1,949	84	2,845	3,548	2,873	1,139	2,241
85	2,585	3,223	2,611	1,034	2,038	85	2,973	3,706	3,003	1,188	2,344
86	2,701	3,368	2,729	1,080	2,129	86	3,107	3,873	3,137	1,243	2,448
87	2,822	3,520	2,851	1,131	2,224	87	3,246	4,048	3,279	1,299	2,559
88	2,950	3,678	2,978	1,180	2,325	88	3,393	4,230	3,426	1,358	2,673
89	3,082	3,843	3,113	1,233	2,429	89	3,544	4,419	3,581	1,418	2,793
90	3,220	4,015	3,254	1,289	2,538	90	3,705	4,619	3,741	1,483	2,919
91	3,366	4,196	3,399	1,348	2,652	91	3,871	4,827	3,910	1,550	3,050
92	3,517	4,385	3,553	1,407	2,772	92	4,044	5,043	4,085	1,619	3,187
93	3,676	4,583	3,712	1,470	2,895	93	4,226	5,271	4,268	1,692	3,330
94	3,840	4,790	3,879	1,537	3,026	94	4,416	5,508	4,460	1,768	3,480
95	4,015	5,006	4,053	1,605	3,162	95	4,615	5,755	4,661	1,846	3,637
96	4,193	5,230	4,235	1,677	3,305	96	4,822	6,016	4,872	1,929	3,798
97	4,381	5,466	4,426	1,753	3,452	97	5,039	6,286	5,090	2,018	3,970
98	4,580	5,712	4,626	1,833	3,608	98	5,266	6,569	5,320	2,108	4,149
99	4,786	5,970	4,835	1,915	3,770	99	5,503	6,864	5,560	2,201	4,337

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY**MICHIGAN Standard Plans FEMALE Rates - ANNUAL**

FOR USE IN ZIP CODES: 480, 482, 483, 485

Attained Age	Preferred					Attained Age	Standard				
	HD						HD				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
65	1,485	1,722	1,501	594	1,130	65	1,709	1,981	1,726	684	1,300
66	1,485	1,722	1,501	594	1,130	66	1,709	1,981	1,726	684	1,300
67	1,485	1,722	1,501	594	1,130	67	1,709	1,981	1,726	684	1,300
68	1,485	1,774	1,501	594	1,143	68	1,709	2,041	1,726	684	1,314
69	1,494	1,828	1,509	597	1,164	69	1,719	2,101	1,736	689	1,338
70	1,509	1,882	1,523	604	1,189	70	1,736	2,165	1,752	695	1,366
71	1,553	1,938	1,568	622	1,224	71	1,785	2,229	1,805	715	1,408
72	1,608	2,005	1,624	644	1,268	72	1,849	2,307	1,867	740	1,457
73	1,663	2,076	1,681	666	1,312	73	1,913	2,387	1,932	765	1,508
74	1,722	2,149	1,740	690	1,358	74	1,980	2,471	2,000	793	1,560
75	1,791	2,234	1,808	717	1,411	75	2,060	2,569	2,080	824	1,623
76	1,862	2,324	1,882	746	1,467	76	2,141	2,672	2,165	858	1,688
77	1,937	2,415	1,957	775	1,527	77	2,228	2,778	2,251	891	1,756
78	2,016	2,513	2,036	807	1,588	78	2,317	2,890	2,342	928	1,826
79	2,095	2,614	2,117	838	1,651	79	2,410	3,005	2,434	964	1,897
80	2,179	2,718	2,200	872	1,718	80	2,506	3,126	2,532	1,003	1,975
81	2,278	2,840	2,301	911	1,794	81	2,619	3,266	2,646	1,048	2,064
82	2,380	2,967	2,404	953	1,875	82	2,736	3,414	2,764	1,096	2,156
83	2,486	3,100	2,512	995	1,959	83	2,860	3,565	2,888	1,145	2,255
84	2,598	3,242	2,625	1,040	2,048	84	2,989	3,727	3,018	1,196	2,355
85	2,715	3,386	2,743	1,087	2,140	85	3,124	3,894	3,155	1,250	2,462
86	2,838	3,538	2,866	1,135	2,236	86	3,264	4,069	3,296	1,306	2,571
87	2,966	3,697	2,995	1,188	2,337	87	3,409	4,253	3,445	1,365	2,688
88	3,100	3,865	3,129	1,240	2,442	88	3,563	4,444	3,600	1,426	2,808
89	3,237	4,037	3,271	1,296	2,552	89	3,724	4,643	3,762	1,489	2,934
90	3,383	4,219	3,418	1,354	2,666	90	3,892	4,851	3,930	1,556	3,066
91	3,536	4,408	3,571	1,415	2,786	91	4,068	5,069	4,107	1,627	3,203
92	3,694	4,607	3,731	1,478	2,911	92	4,248	5,298	4,292	1,701	3,349
93	3,860	4,815	3,900	1,545	3,042	93	4,440	5,536	4,484	1,777	3,498
94	4,033	5,031	4,075	1,615	3,179	94	4,639	5,786	4,687	1,857	3,655
95	4,216	5,258	4,258	1,686	3,322	95	4,849	6,047	4,897	1,940	3,821
96	4,405	5,495	4,450	1,763	3,470	96	5,066	6,320	5,117	2,026	3,991
97	4,603	5,742	4,650	1,842	3,627	97	5,294	6,604	5,348	2,118	4,170
98	4,811	6,001	4,860	1,925	3,790	98	5,532	6,902	5,590	2,215	4,359
99	5,027	6,270	5,079	2,011	3,961	99	5,783	7,211	5,840	2,313	4,554

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

MICHIGAN Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 481, 484, 486-489

Attained Age	Preferred					Attained Age	Standard				
	HD						HD				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
65	1,396	1,619	1,411	558	1,063	65	1,607	1,862	1,623	643	1,222
66	1,396	1,619	1,411	558	1,063	66	1,607	1,862	1,623	643	1,222
67	1,396	1,619	1,411	558	1,063	67	1,607	1,862	1,623	643	1,222
68	1,396	1,668	1,411	558	1,074	68	1,607	1,918	1,623	643	1,236
69	1,404	1,718	1,418	562	1,095	69	1,616	1,976	1,632	648	1,258
70	1,418	1,770	1,432	567	1,118	70	1,632	2,035	1,647	653	1,285
71	1,460	1,822	1,474	585	1,151	71	1,678	2,096	1,697	673	1,324
72	1,512	1,885	1,527	605	1,192	72	1,738	2,169	1,756	696	1,369
73	1,564	1,952	1,580	626	1,233	73	1,798	2,245	1,817	720	1,417
74	1,619	2,020	1,635	649	1,277	74	1,862	2,323	1,880	746	1,467
75	1,684	2,100	1,700	674	1,327	75	1,937	2,415	1,955	774	1,526
76	1,751	2,185	1,769	701	1,380	76	2,013	2,512	2,035	807	1,587
77	1,821	2,271	1,840	729	1,436	77	2,095	2,612	2,116	837	1,651
78	1,895	2,362	1,914	758	1,493	78	2,178	2,717	2,201	873	1,717
79	1,969	2,457	1,990	788	1,552	79	2,266	2,826	2,288	906	1,783
80	2,049	2,556	2,069	820	1,615	80	2,356	2,939	2,380	943	1,857
81	2,141	2,670	2,163	857	1,686	81	2,462	3,070	2,488	985	1,940
82	2,237	2,789	2,260	896	1,763	82	2,572	3,210	2,599	1,031	2,027
83	2,338	2,915	2,362	936	1,842	83	2,689	3,352	2,715	1,077	2,120
84	2,443	3,048	2,468	978	1,925	84	2,810	3,504	2,838	1,125	2,214
85	2,553	3,184	2,579	1,022	2,012	85	2,937	3,661	2,966	1,175	2,314
86	2,668	3,327	2,695	1,067	2,103	86	3,069	3,826	3,099	1,228	2,417
87	2,788	3,475	2,816	1,117	2,198	87	3,205	3,998	3,239	1,284	2,527
88	2,914	3,633	2,942	1,166	2,296	88	3,350	4,178	3,384	1,341	2,640
89	3,043	3,796	3,076	1,218	2,399	89	3,501	4,366	3,537	1,400	2,758
90	3,181	3,966	3,213	1,273	2,507	90	3,659	4,561	3,695	1,463	2,883
91	3,324	4,145	3,358	1,330	2,620	91	3,824	4,766	3,861	1,530	3,011
92	3,473	4,331	3,508	1,390	2,736	92	3,994	4,981	4,036	1,599	3,148
93	3,629	4,527	3,667	1,453	2,860	93	4,174	5,205	4,216	1,670	3,289
94	3,792	4,730	3,831	1,518	2,989	94	4,361	5,440	4,406	1,746	3,437
95	3,964	4,943	4,003	1,586	3,123	95	4,559	5,686	4,604	1,824	3,592
96	4,142	5,166	4,183	1,658	3,263	96	4,763	5,942	4,811	1,905	3,752
97	4,328	5,399	4,372	1,732	3,410	97	4,977	6,208	5,028	1,992	3,920
98	4,523	5,642	4,569	1,810	3,564	98	5,201	6,489	5,255	2,082	4,098
99	4,726	5,895	4,775	1,891	3,724	99	5,437	6,779	5,491	2,175	4,282

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

MICHIGAN Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 480-489

Attained Age	Preferred					Attained Age	Standard				
	HD						HD				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
65	1,257	1,457	1,270	502	956	65	1,446	1,676	1,460	579	1,100
66	1,257	1,457	1,270	502	956	66	1,446	1,676	1,460	579	1,100
67	1,257	1,457	1,270	502	956	67	1,446	1,676	1,460	579	1,100
68	1,257	1,501	1,270	502	967	68	1,446	1,727	1,460	579	1,112
69	1,264	1,546	1,277	506	985	69	1,454	1,778	1,469	583	1,133
70	1,277	1,593	1,289	511	1,006	70	1,469	1,832	1,482	588	1,156
71	1,314	1,640	1,326	526	1,036	71	1,510	1,886	1,527	605	1,191
72	1,361	1,697	1,374	545	1,073	72	1,564	1,952	1,580	626	1,232
73	1,407	1,756	1,422	563	1,110	73	1,619	2,020	1,635	648	1,276
74	1,457	1,818	1,472	584	1,149	74	1,676	2,091	1,692	671	1,320
75	1,516	1,890	1,530	606	1,194	75	1,743	2,173	1,760	697	1,373
76	1,576	1,967	1,593	631	1,242	76	1,812	2,261	1,832	726	1,428
77	1,639	2,044	1,656	656	1,292	77	1,886	2,351	1,904	754	1,486
78	1,706	2,126	1,722	683	1,344	78	1,960	2,445	1,981	786	1,545
79	1,772	2,212	1,791	709	1,397	79	2,039	2,543	2,059	815	1,605
80	1,844	2,300	1,862	738	1,454	80	2,121	2,645	2,142	848	1,671
81	1,927	2,403	1,947	771	1,518	81	2,216	2,763	2,239	886	1,746
82	2,014	2,510	2,034	806	1,587	82	2,315	2,889	2,339	928	1,824
83	2,104	2,623	2,126	842	1,658	83	2,420	3,017	2,444	969	1,908
84	2,199	2,743	2,221	880	1,733	84	2,529	3,154	2,554	1,012	1,992
85	2,297	2,865	2,321	919	1,811	85	2,643	3,295	2,669	1,057	2,083
86	2,401	2,994	2,425	961	1,892	86	2,762	3,443	2,789	1,105	2,176
87	2,509	3,128	2,534	1,005	1,978	87	2,885	3,598	2,915	1,155	2,274
88	2,623	3,270	2,648	1,049	2,066	88	3,015	3,760	3,046	1,207	2,376
89	2,739	3,416	2,768	1,097	2,159	89	3,151	3,929	3,183	1,260	2,482
90	2,863	3,570	2,892	1,146	2,256	90	3,293	4,105	3,325	1,317	2,595
91	2,992	3,730	3,022	1,197	2,358	91	3,442	4,289	3,475	1,377	2,710
92	3,126	3,898	3,157	1,251	2,463	92	3,595	4,483	3,632	1,439	2,833
93	3,266	4,074	3,300	1,308	2,574	93	3,757	4,685	3,794	1,503	2,960
94	3,413	4,257	3,448	1,366	2,690	94	3,925	4,896	3,966	1,571	3,093
95	3,568	4,449	3,603	1,427	2,811	95	4,103	5,117	4,143	1,641	3,233
96	3,728	4,650	3,765	1,492	2,936	96	4,287	5,348	4,330	1,714	3,377
97	3,895	4,859	3,935	1,559	3,069	97	4,479	5,588	4,525	1,793	3,528
98	4,071	5,078	4,112	1,629	3,207	98	4,681	5,840	4,730	1,874	3,688
99	4,254	5,306	4,297	1,702	3,351	99	4,893	6,101	4,942	1,957	3,854

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

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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day All but \$816 a day \$0 \$0	\$0 \$408 a day \$816 a day 100% of Medicare eligible expenses \$0	\$1632 (Part A deductible) \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 \$0 \$0	\$0 Up to \$204 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day All but \$816 a day \$0 \$0	\$1632 (Part A deductible) \$408 a day \$816 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 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

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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day All but \$816 a day \$0 \$0	\$1632 (Part A deductible) \$408 a day \$816 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 Durable medical equipment	100%	\$0	\$0
- 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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day All but \$816 a day \$0 \$0	\$1632 (Part A deductible) \$408 a day \$816 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 Durable medical equipment	100%	\$0	\$0
- 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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day All but \$816 a day \$0 \$0	\$1632 (Part A deductible) \$408 a day \$816 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 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.	 \$240 (Part B deductible) 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 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

(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	100%	\$0	\$0
- First \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (Part B deductible)
- 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 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.