ACE PROPERTY & CASUALTY INSURANCE COMPANY
Outline of Medicare Supplement Coverage
Benefit Plans A, F, G, N and High Deductible Plan G

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available in your state. Only applicants' **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants									Medicare first eligible before 2020 only		
	A	B	D	G	G[1]	K	L	M	N	C	F	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Medicare Part B coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓ copays apply[3]	✓	✓	
Blood (first three pints)	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Part A hospice care coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Skilled nursing facility coinsurance			✓	✓		50%	75%	✓	✓	✓	✓	
Medicare Part A deductible		✓	✓	✓		50%	75%	50%	✓	✓	✓	
Medicare Part B deductible										✓	✓	
Medicare Part B excess charges				✓							✓	
Foreign travel emergency (up to plan limits)			✓	✓				✓	✓	✓	✓	
Out-of-pocket limit in 2024[2]						$7060[2]	$3530[2]					

[1]Plans F and G also have a high deductible option which requires first paying a plan deductible of $2800 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

[3]Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

Effective 08-01-2023

ACE PROPERTY & CASUALTY INSURANCE COMPANY

Policy Fee $25

ARIZONA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 850, 851, 852, 85301-85320, 85322-85324, 85326-85327, 85329-85332, 85335, 85337-85340, 85342-85343, 85345, 85351, 85355, 85358, 85361-85363, 85372-85399

	Preferred				
Issue Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,613	1,856	1,630	640	1,193
66	1,613	1,856	1,630	640	1,193
67	1,613	1,856	1,630	640	1,193
68	1,613	1,856	1,630	640	1,230
69	1,647	1,896	1,665	654	1,255
70	1,684	1,938	1,701	667	1,285
71	1,719	1,979	1,737	682	1,310
72	1,764	2,031	1,783	700	1,344
73	1,811	2,084	1,829	718	1,380
74	1,859	2,139	1,877	736	1,415
75	1,907	2,194	1,927	756	1,453
76	1,958	2,250	1,977	775	1,490
77	2,016	2,320	2,036	799	1,536
78	2,077	2,392	2,100	824	1,584
79	2,143	2,463	2,163	849	1,631
80	2,208	2,540	2,230	876	1,683
81	2,274	2,619	2,298	902	1,732
82	2,343	2,696	2,367	929	1,786
83	2,426	2,791	2,451	961	1,848
84	2,510	2,889	2,537	996	1,913
85	2,599	2,992	2,626	1,030	1,981
86	2,691	3,098	2,718	1,066	2,051
87	2,785	3,205	2,813	1,104	2,123
88	2,883	3,317	2,911	1,144	2,197
89	2,983	3,434	3,013	1,183	2,276
90	3,087	3,553	3,119	1,224	2,356
91	3,195	3,679	3,228	1,268	2,438
92	3,306	3,807	3,339	1,310	2,523
93	3,422	3,939	3,457	1,357	2,610
94	3,542	4,077	3,577	1,404	2,703
95	3,665	4,220	3,700	1,453	2,795
96	3,791	4,368	3,829	1,503	2,893
97	3,928	4,523	3,967	1,557	2,997
98	4,084	4,705	4,125	1,618	3,116
99	4,249	4,892	4,292	1,684	3,242

	Standard				
Issue Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,855	2,136	1,873	735	1,373
66	1,855	2,136	1,873	735	1,373
67	1,855	2,136	1,873	735	1,373
68	1,855	2,136	1,873	735	1,413
69	1,894	2,180	1,915	752	1,445
70	1,937	2,228	1,957	768	1,476
71	1,977	2,276	1,998	784	1,507
72	2,030	2,334	2,050	806	1,546
73	2,082	2,397	2,104	825	1,588
74	2,138	2,459	2,160	847	1,627
75	2,194	2,524	2,216	869	1,670
76	2,252	2,588	2,272	893	1,713
77	2,318	2,669	2,342	918	1,766
78	2,391	2,751	2,414	948	1,821
79	2,464	2,833	2,488	977	1,876
80	2,540	2,920	2,564	1,007	1,936
81	2,616	3,011	2,642	1,038	1,992
82	2,695	3,100	2,723	1,068	2,054
83	2,790	3,209	2,817	1,106	2,125
84	2,886	3,324	2,917	1,145	2,200
85	2,991	3,440	3,020	1,185	2,279
86	3,094	3,561	3,124	1,227	2,359
87	3,202	3,686	3,234	1,269	2,441
88	3,314	3,814	3,348	1,314	2,527
89	3,430	3,948	3,465	1,361	2,618
90	3,551	4,086	3,586	1,407	2,709
91	3,675	4,232	3,712	1,458	2,802
92	3,801	4,377	3,840	1,507	2,902
93	3,936	4,530	3,974	1,560	3,002
94	4,074	4,689	4,114	1,614	3,108
95	4,214	4,854	4,257	1,670	3,214
96	4,360	5,024	4,405	1,728	3,327
97	4,515	5,203	4,562	1,791	3,446
98	4,696	5,411	4,744	1,861	3,584
99	4,886	5,626	4,934	1,937	3,729

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY

ARIZONA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 850, 851, 852, 85301-85320, 85322-85324, 85326-85327, 85329-85332, 85335, 85337-85340, 85342-85343, 85345, 85351, 85355, 85358, 85361-85363, 85372-85399

	Preferred				
Issue Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,530	1,761	1,546	607	1,132
66	1,530	1,761	1,546	607	1,132
67	1,530	1,761	1,546	607	1,132
68	1,530	1,761	1,546	607	1,166
69	1,562	1,798	1,579	620	1,190
70	1,597	1,838	1,613	632	1,219
71	1,631	1,877	1,647	647	1,243
72	1,673	1,926	1,691	664	1,274
73	1,717	1,977	1,735	681	1,309
74	1,763	2,028	1,781	698	1,342
75	1,809	2,081	1,828	717	1,378
76	1,857	2,134	1,875	735	1,413
77	1,912	2,201	1,931	758	1,457
78	1,970	2,269	1,991	782	1,502
79	2,032	2,337	2,052	806	1,547
80	2,094	2,409	2,115	831	1,596
81	2,157	2,484	2,180	855	1,643
82	2,222	2,557	2,245	881	1,694
83	2,300	2,647	2,325	912	1,753
84	2,380	2,740	2,406	944	1,814
85	2,465	2,838	2,491	977	1,879
86	2,552	2,938	2,577	1,011	1,945
87	2,642	3,040	2,668	1,047	2,013
88	2,734	3,146	2,761	1,085	2,084
89	2,829	3,257	2,857	1,122	2,159
90	2,928	3,370	2,958	1,161	2,234
91	3,030	3,489	3,061	1,203	2,313
92	3,135	3,611	3,166	1,243	2,393
93	3,245	3,736	3,279	1,287	2,475
94	3,360	3,866	3,393	1,332	2,563
95	3,476	4,002	3,510	1,378	2,651
96	3,596	4,143	3,632	1,426	2,744
97	3,725	4,290	3,762	1,476	2,843
98	3,873	4,463	3,913	1,535	2,956
99	4,030	4,640	4,070	1,597	3,075

	Standard				
Issue Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,759	2,026	1,777	698	1,302
66	1,759	2,026	1,777	698	1,302
67	1,759	2,026	1,777	698	1,302
68	1,759	2,026	1,777	698	1,340
69	1,796	2,068	1,816	713	1,370
70	1,837	2,114	1,856	728	1,400
71	1,875	2,159	1,895	743	1,429
72	1,925	2,214	1,945	764	1,467
73	1,975	2,273	1,995	783	1,506
74	2,027	2,333	2,049	804	1,543
75	2,081	2,394	2,102	824	1,584
76	2,136	2,454	2,155	847	1,625
77	2,198	2,532	2,222	871	1,675
78	2,267	2,609	2,290	899	1,727
79	2,337	2,687	2,360	926	1,780
80	2,409	2,770	2,432	955	1,836
81	2,481	2,856	2,506	985	1,890
82	2,556	2,940	2,582	1,013	1,948
83	2,646	3,044	2,672	1,049	2,015
84	2,737	3,153	2,767	1,086	2,087
85	2,837	3,263	2,864	1,124	2,161
86	2,934	3,378	2,963	1,163	2,237
87	3,037	3,496	3,067	1,204	2,315
88	3,143	3,618	3,175	1,247	2,397
89	3,253	3,745	3,286	1,291	2,483
90	3,368	3,875	3,401	1,335	2,569
91	3,485	4,014	3,520	1,383	2,658
92	3,605	4,152	3,642	1,429	2,753
93	3,733	4,296	3,769	1,479	2,847
94	3,864	4,447	3,902	1,531	2,948
95	3,996	4,604	4,037	1,584	3,048
96	4,135	4,765	4,178	1,639	3,156
97	4,282	4,935	4,327	1,698	3,268
98	4,454	5,132	4,500	1,765	3,400
99	4,634	5,336	4,680	1,837	3,536

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

ARIZONA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 850, 851, 852, 85301-85320, 85322-85324, 85326-85327, 85329-85332, 85335, 85337-85340, 85342-85343, 85345, 85351, 85355, 85358, 85361-85363, 85372-85399

	Preferred				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
65	1,434	1,650	1,449	569	1,060
66	1,434	1,650	1,449	569	1,060
67	1,434	1,650	1,449	569	1,060
68	1,434	1,650	1,449	569	1,093
69	1,464	1,686	1,480	581	1,116
70	1,497	1,722	1,511	593	1,142
71	1,529	1,759	1,544	606	1,164
72	1,568	1,804	1,584	622	1,194
73	1,609	1,852	1,626	638	1,227
74	1,652	1,901	1,669	655	1,258
75	1,694	1,950	1,712	672	1,290
76	1,741	1,999	1,757	689	1,325
77	1,791	2,063	1,810	710	1,366
78	1,847	2,127	1,866	732	1,408
79	1,904	2,190	1,924	755	1,450
80	1,963	2,258	1,981	778	1,496
81	2,022	2,327	2,042	802	1,539
82	2,083	2,397	2,105	825	1,588
83	2,156	2,481	2,178	855	1,642
84	2,231	2,568	2,254	885	1,701
85	2,311	2,659	2,334	915	1,761
86	2,392	2,753	2,415	948	1,823
87	2,475	2,850	2,501	982	1,887
88	2,561	2,949	2,588	1,016	1,953
89	2,651	3,052	2,678	1,052	2,024
90	2,743	3,158	2,772	1,088	2,093
91	2,840	3,271	2,869	1,127	2,167
92	2,939	3,384	2,968	1,164	2,243
93	3,041	3,502	3,072	1,206	2,319
94	3,148	3,625	3,179	1,248	2,403
95	3,257	3,752	3,289	1,290	2,485
96	3,369	3,882	3,404	1,336	2,571
97	3,491	4,021	3,526	1,383	2,664
98	3,631	4,182	3,667	1,439	2,771
99	3,777	4,349	3,815	1,497	2,882

	Standard				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
65	1,649	1,898	1,666	654	1,220
66	1,649	1,898	1,666	654	1,220
67	1,649	1,898	1,666	654	1,220
68	1,649	1,898	1,666	654	1,256
69	1,684	1,939	1,702	668	1,284
70	1,722	1,980	1,740	682	1,312
71	1,757	2,024	1,776	697	1,340
72	1,803	2,075	1,822	716	1,375
73	1,851	2,130	1,870	733	1,411
74	1,900	2,186	1,920	754	1,447
75	1,949	2,244	1,969	773	1,484
76	2,001	2,300	2,020	793	1,522
77	2,061	2,372	2,081	817	1,571
78	2,124	2,445	2,146	842	1,619
79	2,190	2,518	2,213	868	1,668
80	2,257	2,597	2,280	896	1,720
81	2,326	2,676	2,348	922	1,770
82	2,397	2,756	2,419	950	1,826
83	2,479	2,853	2,505	984	1,889
84	2,565	2,955	2,593	1,018	1,956
85	2,658	3,059	2,685	1,053	2,026
86	2,749	3,166	2,778	1,091	2,096
87	2,846	3,277	2,875	1,128	2,171
88	2,946	3,392	2,977	1,168	2,246
89	3,050	3,509	3,079	1,210	2,326
90	3,157	3,631	3,187	1,251	2,408
91	3,267	3,761	3,299	1,295	2,492
92	3,379	3,892	3,413	1,340	2,580
93	3,499	4,026	3,533	1,386	2,668
94	3,620	4,167	3,656	1,435	2,762
95	3,745	4,315	3,784	1,484	2,857
96	3,875	4,465	3,915	1,535	2,957
97	4,014	4,625	4,055	1,591	3,064
98	4,174	4,810	4,218	1,655	3,187
99	4,343	5,001	4,387	1,721	3,314

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

ARIZONA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 850, 851, 852, 85301-85320, 85322-85324, 85326-85327, 85329-85332, 85335, 85337-85340, 85342-85343, 85345, 85351, 85355, 85358, 85361-85363, 85372-85399

	Preferred				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
65	1,360	1,565	1,374	540	1,006
66	1,360	1,565	1,374	540	1,006
67	1,360	1,565	1,374	540	1,006
68	1,360	1,565	1,374	540	1,036
69	1,389	1,599	1,403	551	1,058
70	1,420	1,633	1,434	563	1,083
71	1,450	1,669	1,465	575	1,104
72	1,487	1,711	1,503	590	1,133
73	1,526	1,757	1,542	605	1,163
74	1,567	1,803	1,583	621	1,193
75	1,607	1,849	1,624	637	1,224
76	1,651	1,896	1,667	653	1,256
77	1,699	1,957	1,716	674	1,296
78	1,751	2,017	1,770	695	1,336
79	1,806	2,077	1,825	716	1,375
80	1,862	2,141	1,879	738	1,419
81	1,918	2,207	1,937	761	1,460
82	1,976	2,273	1,996	783	1,506
83	2,045	2,353	2,065	811	1,558
84	2,116	2,436	2,138	839	1,613
85	2,192	2,522	2,214	868	1,671
86	2,268	2,611	2,291	899	1,729
87	2,347	2,703	2,372	931	1,790
88	2,429	2,797	2,455	963	1,852
89	2,514	2,894	2,540	998	1,919
90	2,602	2,995	2,629	1,032	1,985
91	2,694	3,102	2,721	1,069	2,055
92	2,787	3,209	2,815	1,104	2,127
93	2,885	3,321	2,914	1,143	2,200
94	2,986	3,438	3,015	1,184	2,279
95	3,089	3,558	3,120	1,224	2,357
96	3,196	3,682	3,229	1,267	2,439
97	3,311	3,814	3,344	1,312	2,527
98	3,443	3,967	3,478	1,364	2,628
99	3,582	4,125	3,618	1,420	2,734

	Standard				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
65	1,564	1,800	1,580	620	1,157
66	1,564	1,800	1,580	620	1,157
67	1,564	1,800	1,580	620	1,157
68	1,564	1,800	1,580	620	1,191
69	1,597	1,839	1,614	633	1,218
70	1,633	1,878	1,650	647	1,245
71	1,667	1,919	1,684	661	1,271
72	1,711	1,968	1,728	679	1,304
73	1,755	2,020	1,774	696	1,339
74	1,802	2,073	1,821	715	1,372
75	1,849	2,128	1,868	733	1,407
76	1,898	2,182	1,916	752	1,444
77	1,954	2,249	1,974	775	1,490
78	2,015	2,319	2,035	799	1,536
79	2,077	2,388	2,099	823	1,582
80	2,141	2,463	2,162	850	1,631
81	2,206	2,538	2,227	875	1,679
82	2,273	2,614	2,295	901	1,732
83	2,351	2,706	2,376	933	1,792
84	2,433	2,802	2,459	965	1,855
85	2,521	2,901	2,546	999	1,921
86	2,608	3,002	2,635	1,034	1,988
87	2,699	3,108	2,727	1,070	2,059
88	2,794	3,217	2,823	1,108	2,130
89	2,892	3,328	2,921	1,147	2,206
90	2,994	3,444	3,023	1,186	2,284
91	3,098	3,567	3,129	1,229	2,363
92	3,205	3,691	3,237	1,271	2,447
93	3,319	3,819	3,351	1,315	2,531
94	3,434	3,953	3,468	1,361	2,620
95	3,552	4,092	3,589	1,407	2,710
96	3,676	4,235	3,714	1,456	2,804
97	3,807	4,387	3,846	1,509	2,906
98	3,959	4,562	4,000	1,570	3,023
99	4,119	4,743	4,161	1,632	3,143

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

Household Discount Factor .93

PREMIUM INFORMATION

We, ACE Property & Casualty Insurance Company, can only raise your premium if we raise the premium for all policies like yours in the same state where your policy was issued.

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.

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	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			

****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	100%	$0	$0
Durable medical equipment - First $240 of Medicare Approved Amounts*	$0	$240 (Part B deductible)	$0
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0
You must meet Medicare's requirements, including a doctor's certification of terminal illness.			

****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.