

ACE PROPERTY & CASUALTY INSURANCE COMPANY
State of Domicile: Pennsylvania
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.

ACE PROPERTY & CASUALTY INSURANCE COMPANY**UTAH Standard Plans MALE Rates - ANNUAL**

FOR USE IN ZIP CODES: ALL OF STATE

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	1,409	1,648	1,423	570	1,056	65	1,620	1,896	1,636	655	1,214
66	1,409	1,648	1,423	570	1,056	66	1,620	1,896	1,636	655	1,214
67	1,409	1,648	1,423	570	1,056	67	1,620	1,896	1,636	655	1,214
68	1,409	1,694	1,423	570	1,061	68	1,620	1,947	1,636	655	1,220
69	1,416	1,744	1,430	572	1,074	69	1,629	2,006	1,645	658	1,237
70	1,435	1,797	1,449	580	1,095	70	1,650	2,066	1,666	667	1,259
71	1,477	1,851	1,492	597	1,127	71	1,699	2,128	1,716	686	1,297
72	1,529	1,915	1,543	618	1,167	72	1,759	2,203	1,775	710	1,342
73	1,583	1,982	1,598	640	1,207	73	1,820	2,280	1,838	735	1,389
74	1,638	2,051	1,654	661	1,250	74	1,883	2,359	1,902	761	1,436
75	1,704	2,133	1,720	687	1,300	75	1,958	2,454	1,977	791	1,494
76	1,771	2,219	1,790	716	1,351	76	2,037	2,551	2,058	824	1,554
77	1,842	2,308	1,861	745	1,406	77	2,117	2,654	2,139	856	1,616
78	1,916	2,399	1,934	775	1,462	78	2,204	2,759	2,226	890	1,682
79	1,993	2,496	2,012	805	1,520	79	2,291	2,870	2,314	926	1,747
80	2,072	2,595	2,094	837	1,581	80	2,383	2,985	2,408	963	1,818
81	2,153	2,696	2,176	869	1,642	81	2,475	3,101	2,501	1,000	1,889
82	2,237	2,801	2,261	904	1,707	82	2,572	3,222	2,599	1,040	1,962
83	2,324	2,910	2,349	939	1,773	83	2,672	3,348	2,700	1,081	2,039
84	2,415	3,023	2,441	976	1,842	84	2,776	3,479	2,805	1,123	2,118
85	2,510	3,141	2,537	1,014	1,914	85	2,884	3,614	2,914	1,167	2,201
86	2,607	3,264	2,635	1,054	1,988	86	2,996	3,755	3,027	1,213	2,287
87	2,709	3,390	2,738	1,095	2,066	87	3,113	3,902	3,146	1,259	2,376
88	2,815	3,522	2,845	1,138	2,147	88	3,234	4,054	3,269	1,308	2,469
89	2,926	3,660	2,957	1,182	2,230	89	3,360	4,212	3,397	1,359	2,566
90	3,040	3,802	3,072	1,228	2,317	90	3,491	4,376	3,529	1,412	2,666
91	3,158	3,951	3,192	1,276	2,408	91	3,628	4,547	3,666	1,467	2,770
92	3,281	4,105	3,317	1,326	2,501	92	3,769	4,725	3,808	1,525	2,878
93	3,409	4,265	3,446	1,378	2,599	93	3,916	4,909	3,957	1,584	2,990
94	3,542	4,431	3,580	1,432	2,700	94	4,068	5,100	4,111	1,645	3,106
95	3,681	4,604	3,719	1,488	2,805	95	4,228	5,299	4,271	1,710	3,227
96	3,824	4,784	3,864	1,546	2,914	96	4,393	5,506	4,438	1,776	3,353
97	3,973	4,970	4,014	1,607	3,027	97	4,565	5,720	4,610	1,846	3,484
98	4,128	5,164	4,171	1,669	3,146	98	4,742	5,944	4,790	1,918	3,620
99	4,289	5,365	4,334	1,735	3,269	99	4,928	6,176	4,977	1,993	3,762

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

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

FOR USE IN ZIP CODES: ALL OF STATE

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	1,252	1,465	1,266	505	937	65	1,440	1,685	1,455	582	1,078
66	1,252	1,465	1,266	505	937	66	1,440	1,685	1,455	582	1,078
67	1,252	1,465	1,266	505	937	67	1,440	1,685	1,455	582	1,078
68	1,252	1,505	1,266	505	944	68	1,440	1,731	1,455	582	1,085
69	1,258	1,550	1,271	508	956	69	1,448	1,784	1,462	586	1,098
70	1,275	1,597	1,288	515	973	70	1,466	1,837	1,481	593	1,119
71	1,314	1,645	1,326	530	1,002	71	1,510	1,892	1,525	610	1,153
72	1,359	1,701	1,373	550	1,037	72	1,563	1,957	1,579	631	1,193
73	1,407	1,762	1,421	569	1,073	73	1,617	2,026	1,634	653	1,233
74	1,456	1,824	1,471	589	1,111	74	1,673	2,097	1,690	676	1,277
75	1,513	1,897	1,529	612	1,155	75	1,741	2,181	1,758	703	1,328
76	1,575	1,972	1,591	636	1,201	76	1,811	2,268	1,829	732	1,382
77	1,637	2,051	1,654	661	1,249	77	1,882	2,359	1,902	761	1,436
78	1,702	2,133	1,720	687	1,300	78	1,958	2,453	1,977	791	1,494
79	1,770	2,219	1,789	716	1,351	79	2,037	2,551	2,057	823	1,554
80	1,842	2,307	1,861	745	1,405	80	2,117	2,654	2,138	856	1,616
81	1,914	2,397	1,933	774	1,460	81	2,200	2,758	2,221	889	1,680
82	1,988	2,491	2,009	804	1,517	82	2,285	2,865	2,308	924	1,745
83	2,066	2,588	2,087	835	1,577	83	2,374	2,976	2,398	960	1,813
84	2,147	2,688	2,168	867	1,638	84	2,467	3,093	2,492	997	1,883
85	2,230	2,793	2,253	902	1,701	85	2,564	3,214	2,589	1,036	1,957
86	2,317	2,903	2,340	937	1,768	86	2,663	3,339	2,689	1,076	2,033
87	2,408	3,016	2,432	973	1,837	87	2,767	3,469	2,794	1,118	2,112
88	2,501	3,134	2,526	1,012	1,908	88	2,876	3,605	2,904	1,162	2,194
89	2,599	3,256	2,625	1,051	1,983	89	2,988	3,745	3,017	1,207	2,280
90	2,700	3,383	2,727	1,092	2,060	90	3,104	3,891	3,135	1,254	2,368
91	2,805	3,515	2,833	1,135	2,140	91	3,225	4,042	3,257	1,303	2,461
92	2,914	3,652	2,943	1,179	2,224	92	3,351	4,201	3,384	1,354	2,556
93	3,027	3,795	3,058	1,225	2,310	93	3,482	4,365	3,516	1,407	2,656
94	3,146	3,943	3,177	1,273	2,400	94	3,618	4,535	3,654	1,462	2,760
95	3,269	4,097	3,301	1,323	2,494	95	3,760	4,712	3,796	1,519	2,868
96	3,397	4,257	3,430	1,375	2,592	96	3,906	4,896	3,944	1,579	2,981
97	3,529	4,423	3,564	1,429	2,693	97	4,058	5,088	4,098	1,640	3,097
98	3,666	4,596	3,703	1,485	2,798	98	4,216	5,286	4,258	1,705	3,218
99	3,808	4,775	3,848	1,543	2,907	99	4,380	5,492	4,424	1,771	3,344

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	\$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 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 <ul style="list-style-type: none">- First \$240 of Medicare Approved Amounts*- Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$240 (Unless Part B deductible has been met) \$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 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 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.