

**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. Only applicants' **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

In Colorado, it is a requirement that all plans offered by ACE Property & Casualty Insurance Company are available to under age 65 Medicare qualified individuals

**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 <sup>1</sup>	K	L	M	N	C	F	F <sup>1</sup>
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 <sup>3</sup>	✓	✓	
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 <sup>2</sup>						\$7060 <sup>2</sup>	\$3530 <sup>2</sup>					

<sup>1</sup>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.

<sup>2</sup>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.

<sup>3</sup>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.

## COLORADO Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 800-802

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
Under 65	2,447	2,863	2,471	990	1,796	Under 65	2,813	3,292	2,841	1,139	2,064
65	1,631	1,908	1,647	659	1,197	65	1,876	2,195	1,894	759	1,376
66	1,631	1,908	1,647	659	1,197	66	1,876	2,195	1,894	759	1,376
67	1,631	1,908	1,647	659	1,197	67	1,876	2,195	1,894	759	1,376
68	1,631	1,961	1,647	659	1,203	68	1,876	2,254	1,894	759	1,383
69	1,640	2,019	1,655	662	1,218	69	1,885	2,322	1,905	762	1,402
70	1,661	2,080	1,677	672	1,241	70	1,911	2,392	1,929	772	1,428
71	1,710	2,143	1,728	691	1,278	71	1,967	2,464	1,987	795	1,470
72	1,770	2,217	1,787	715	1,323	72	2,036	2,549	2,056	823	1,522
73	1,832	2,295	1,850	741	1,369	73	2,107	2,639	2,127	851	1,575
74	1,896	2,374	1,914	766	1,417	74	2,180	2,731	2,202	881	1,629
75	1,972	2,470	1,992	796	1,474	75	2,268	2,841	2,289	916	1,694
76	2,051	2,569	2,072	829	1,532	76	2,358	2,954	2,382	953	1,762
77	2,132	2,672	2,154	862	1,595	77	2,451	3,072	2,477	991	1,832
78	2,218	2,778	2,240	897	1,658	78	2,551	3,194	2,576	1,031	1,907
79	2,306	2,889	2,329	932	1,724	79	2,652	3,323	2,679	1,072	1,982
80	2,398	3,004	2,424	969	1,792	80	2,759	3,456	2,787	1,114	2,061
81	2,506	3,140	2,531	1,013	1,874	81	2,882	3,611	2,911	1,165	2,154
82	2,620	3,280	2,645	1,058	1,958	82	3,012	3,773	3,042	1,217	2,251
83	2,737	3,428	2,765	1,106	2,046	83	3,147	3,942	3,179	1,272	2,353
84	2,859	3,582	2,888	1,156	2,138	84	3,289	4,119	3,321	1,329	2,459
85	2,989	3,743	3,019	1,208	2,235	85	3,436	4,305	3,471	1,388	2,569
86	3,123	3,912	3,154	1,262	2,335	86	3,592	4,499	3,628	1,452	2,686
87	3,263	4,087	3,296	1,319	2,441	87	3,752	4,702	3,791	1,516	2,806
88	3,410	4,271	3,445	1,377	2,549	88	3,922	4,913	3,962	1,585	2,932
89	3,563	4,464	3,600	1,440	2,664	89	4,098	5,133	4,139	1,655	3,066
90	3,723	4,665	3,762	1,505	2,785	90	4,282	5,365	4,326	1,732	3,203
91	3,891	4,875	3,930	1,573	2,909	91	4,476	5,607	4,519	1,808	3,347
92	4,067	5,094	4,108	1,643	3,042	92	4,677	5,860	4,724	1,890	3,497
93	4,250	5,324	4,292	1,717	3,179	93	4,887	6,123	4,936	1,975	3,655
94	4,441	5,564	4,485	1,794	3,323	94	5,107	6,398	5,158	2,063	3,820
95	4,642	5,814	4,688	1,876	3,471	95	5,337	6,686	5,391	2,156	3,992
96	4,850	6,075	4,898	1,959	3,628	96	5,577	6,987	5,633	2,253	4,172
97	5,067	6,350	5,118	2,047	3,791	97	5,827	7,301	5,887	2,355	4,360
98	5,296	6,636	5,349	2,139	3,963	98	6,090	7,630	6,152	2,460	4,556
99	5,535	6,933	5,590	2,236	4,141	99	6,365	7,974	6,429	2,571	4,761

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

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

FOR USE IN ZIP CODES: ALL EXCEPT 800-802

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
Under 65	2,224	2,603	2,246	900	1,632	Under 65	2,558	2,993	2,583	1,035	1,877
65	1,483	1,735	1,497	600	1,088	65	1,705	1,995	1,722	690	1,251
66	1,483	1,735	1,497	600	1,088	66	1,705	1,995	1,722	690	1,251
67	1,483	1,735	1,497	600	1,088	67	1,705	1,995	1,722	690	1,251
68	1,483	1,783	1,497	600	1,093	68	1,705	2,049	1,722	690	1,257
69	1,491	1,836	1,505	602	1,108	69	1,714	2,111	1,731	693	1,275
70	1,510	1,891	1,525	611	1,129	70	1,737	2,175	1,753	702	1,298
71	1,554	1,948	1,571	628	1,162	71	1,789	2,240	1,806	723	1,337
72	1,609	2,015	1,625	650	1,202	72	1,851	2,318	1,869	748	1,384
73	1,665	2,087	1,682	673	1,244	73	1,915	2,399	1,934	773	1,432
74	1,724	2,158	1,740	696	1,288	74	1,982	2,483	2,002	801	1,481
75	1,793	2,245	1,811	724	1,340	75	2,061	2,583	2,081	833	1,540
76	1,865	2,335	1,883	754	1,393	76	2,144	2,685	2,166	867	1,602
77	1,938	2,429	1,958	783	1,450	77	2,229	2,793	2,252	901	1,665
78	2,016	2,526	2,036	815	1,507	78	2,319	2,904	2,342	937	1,734
79	2,097	2,627	2,118	847	1,568	79	2,411	3,021	2,435	975	1,802
80	2,180	2,731	2,203	881	1,629	80	2,508	3,142	2,533	1,013	1,873
81	2,278	2,855	2,301	921	1,704	81	2,620	3,282	2,647	1,059	1,958
82	2,382	2,982	2,405	961	1,780	82	2,738	3,430	2,765	1,107	2,046
83	2,488	3,116	2,514	1,005	1,860	83	2,861	3,584	2,890	1,156	2,140
84	2,599	3,256	2,626	1,051	1,944	84	2,990	3,744	3,020	1,208	2,235
85	2,717	3,402	2,745	1,098	2,032	85	3,124	3,914	3,156	1,262	2,335
86	2,839	3,556	2,868	1,147	2,123	86	3,266	4,090	3,298	1,320	2,442
87	2,967	3,716	2,996	1,199	2,219	87	3,411	4,275	3,446	1,378	2,551
88	3,100	3,883	3,132	1,252	2,318	88	3,565	4,466	3,601	1,441	2,665
89	3,240	4,058	3,273	1,309	2,422	89	3,726	4,666	3,763	1,505	2,787
90	3,385	4,241	3,420	1,368	2,532	90	3,893	4,877	3,933	1,574	2,912
91	3,538	4,432	3,573	1,430	2,644	91	4,069	5,097	4,109	1,643	3,043
92	3,697	4,631	3,735	1,494	2,765	92	4,252	5,327	4,294	1,718	3,179
93	3,863	4,840	3,902	1,561	2,890	93	4,443	5,566	4,487	1,795	3,323
94	4,037	5,058	4,078	1,631	3,021	94	4,643	5,817	4,689	1,876	3,473
95	4,220	5,286	4,261	1,705	3,156	95	4,852	6,079	4,901	1,960	3,629
96	4,409	5,523	4,453	1,781	3,298	96	5,070	6,351	5,121	2,048	3,793
97	4,607	5,773	4,653	1,861	3,446	97	5,298	6,637	5,352	2,141	3,963
98	4,815	6,032	4,863	1,945	3,603	98	5,536	6,937	5,592	2,236	4,142
99	5,031	6,303	5,082	2,033	3,764	99	5,786	7,249	5,844	2,338	4,329

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

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

FOR USE IN ZIP CODES: 800-802

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
Under 65	2,174	2,545	2,199	878	1,596	Under 65	2,501	2,926	2,526	1,012	1,836
65	1,450	1,696	1,465	586	1,064	65	1,667	1,951	1,684	674	1,223
66	1,450	1,696	1,465	586	1,064	66	1,667	1,951	1,684	674	1,223
67	1,450	1,696	1,465	586	1,064	67	1,667	1,951	1,684	674	1,223
68	1,450	1,742	1,465	586	1,070	68	1,667	2,004	1,684	674	1,231
69	1,457	1,794	1,471	588	1,083	69	1,676	2,064	1,693	678	1,246
70	1,476	1,849	1,491	597	1,104	70	1,698	2,126	1,715	686	1,269
71	1,521	1,905	1,535	613	1,136	71	1,748	2,190	1,765	707	1,307
72	1,573	1,970	1,589	636	1,176	72	1,810	2,266	1,827	731	1,352
73	1,629	2,040	1,644	658	1,217	73	1,872	2,345	1,891	756	1,399
74	1,686	2,111	1,702	681	1,260	74	1,937	2,427	1,957	783	1,448
75	1,752	2,196	1,770	708	1,309	75	2,016	2,525	2,035	814	1,506
76	1,822	2,283	1,842	737	1,362	76	2,096	2,626	2,118	847	1,567
77	1,895	2,374	1,914	766	1,416	77	2,179	2,731	2,202	881	1,629
78	1,971	2,470	1,992	796	1,474	78	2,268	2,840	2,289	916	1,694
79	2,050	2,569	2,070	829	1,532	79	2,358	2,954	2,381	952	1,762
80	2,132	2,670	2,154	862	1,594	80	2,451	3,072	2,476	991	1,832
81	2,228	2,790	2,251	900	1,665	81	2,562	3,209	2,588	1,036	1,915
82	2,328	2,916	2,351	940	1,740	82	2,678	3,354	2,704	1,082	2,001
83	2,432	3,047	2,456	983	1,819	83	2,798	3,504	2,825	1,130	2,091
84	2,542	3,184	2,568	1,027	1,901	84	2,923	3,661	2,952	1,181	2,186
85	2,657	3,328	2,683	1,073	1,987	85	3,055	3,827	3,086	1,234	2,284
86	2,776	3,476	2,804	1,122	2,076	86	3,192	3,999	3,225	1,290	2,387
87	2,900	3,634	2,931	1,172	2,170	87	3,336	4,179	3,370	1,348	2,495
88	3,031	3,797	3,063	1,225	2,266	88	3,486	4,366	3,521	1,408	2,608
89	3,168	3,968	3,199	1,280	2,369	89	3,642	4,563	3,680	1,471	2,725
90	3,311	4,147	3,343	1,337	2,474	90	3,807	4,769	3,845	1,538	2,847
91	3,459	4,333	3,493	1,398	2,587	91	3,978	4,984	4,018	1,607	2,975
92	3,614	4,529	3,651	1,460	2,703	92	4,156	5,208	4,199	1,679	3,108
93	3,778	4,732	3,815	1,526	2,825	93	4,345	5,443	4,387	1,755	3,249
94	3,947	4,945	3,987	1,595	2,954	94	4,539	5,687	4,586	1,834	3,395
95	4,125	5,168	4,167	1,667	3,086	95	4,744	5,944	4,792	1,917	3,549
96	4,310	5,400	4,354	1,741	3,225	96	4,957	6,210	5,007	2,003	3,709
97	4,505	5,643	4,551	1,820	3,369	97	5,180	6,490	5,232	2,093	3,874
98	4,708	5,898	4,755	1,902	3,521	98	5,414	6,782	5,468	2,188	4,050
99	4,919	6,163	4,968	1,988	3,681	99	5,657	7,088	5,714	2,286	4,233

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

## COLORADO Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 800-802

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
Under 65	1,977	2,313	1,999	799	1,451	Under 65	2,274	2,660	2,297	920	1,669
65	1,318	1,542	1,332	532	967	65	1,516	1,773	1,531	613	1,112
66	1,318	1,542	1,332	532	967	66	1,516	1,773	1,531	613	1,112
67	1,318	1,542	1,332	532	967	67	1,516	1,773	1,531	613	1,112
68	1,318	1,584	1,332	532	972	68	1,516	1,822	1,531	613	1,119
69	1,324	1,631	1,338	535	985	69	1,524	1,877	1,539	616	1,133
70	1,342	1,681	1,355	542	1,003	70	1,543	1,933	1,559	624	1,154
71	1,383	1,731	1,396	558	1,033	71	1,590	1,991	1,605	642	1,188
72	1,430	1,791	1,444	579	1,069	72	1,646	2,060	1,661	664	1,229
73	1,481	1,855	1,495	598	1,107	73	1,702	2,132	1,719	688	1,272
74	1,532	1,920	1,548	619	1,145	74	1,761	2,207	1,779	712	1,317
75	1,593	1,997	1,609	644	1,190	75	1,833	2,296	1,850	740	1,370
76	1,657	2,076	1,674	670	1,239	76	1,905	2,387	1,925	770	1,425
77	1,723	2,158	1,740	696	1,287	77	1,981	2,483	2,002	801	1,481
78	1,792	2,245	1,811	724	1,340	78	2,061	2,582	2,081	833	1,540
79	1,863	2,335	1,882	754	1,393	79	2,144	2,685	2,165	866	1,602
80	1,938	2,428	1,958	783	1,449	80	2,229	2,793	2,251	901	1,665
81	2,025	2,537	2,046	818	1,514	81	2,329	2,917	2,353	942	1,741
82	2,116	2,651	2,137	855	1,582	82	2,434	3,049	2,459	983	1,819
83	2,211	2,770	2,233	893	1,653	83	2,543	3,186	2,569	1,027	1,901
84	2,311	2,894	2,334	934	1,728	84	2,658	3,329	2,684	1,074	1,988
85	2,416	3,025	2,439	976	1,806	85	2,778	3,479	2,805	1,122	2,077
86	2,523	3,160	2,549	1,020	1,888	86	2,902	3,636	2,932	1,173	2,170
87	2,637	3,303	2,664	1,066	1,972	87	3,033	3,799	3,064	1,225	2,268
88	2,756	3,452	2,784	1,113	2,060	88	3,169	3,969	3,201	1,280	2,371
89	2,880	3,607	2,908	1,164	2,154	89	3,311	4,148	3,345	1,338	2,477
90	3,010	3,770	3,039	1,216	2,250	90	3,461	4,335	3,496	1,398	2,588
91	3,145	3,939	3,176	1,271	2,352	91	3,617	4,531	3,653	1,461	2,705
92	3,286	4,117	3,319	1,328	2,457	92	3,779	4,734	3,817	1,527	2,826
93	3,434	4,302	3,468	1,387	2,569	93	3,950	4,948	3,989	1,595	2,954
94	3,588	4,496	3,625	1,450	2,685	94	4,126	5,170	4,169	1,668	3,087
95	3,750	4,698	3,788	1,516	2,805	95	4,313	5,403	4,356	1,742	3,226
96	3,918	4,909	3,958	1,583	2,932	96	4,507	5,645	4,552	1,821	3,372
97	4,095	5,130	4,137	1,654	3,062	97	4,709	5,900	4,756	1,903	3,522
98	4,280	5,361	4,323	1,729	3,201	98	4,921	6,166	4,971	1,989	3,682
99	4,472	5,602	4,517	1,807	3,346	99	5,143	6,444	5,194	2,078	3,848

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

## **PREMIUM INFORMATION**

We, ACE Property & Casualty Insurance Company, can only 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. If you move out of Colorado, your premium will continue to be based on the most recent zip code of your residence in Colorado. 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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
<b>SKILLED NURSING FACILITY CARE*</b> 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 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$204 a day \$0	\$0 \$0 \$0	\$0 Up to \$204 a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES –</b> 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
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY</b> <b>SERVICES – TESTS FOR DIAGNOSTIC</b> <b>SERVICES</b>	100%	\$0	\$0

## PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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
<b>SKILLED NURSING FACILITY CARE*</b> 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 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES –</b> 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
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY SERVICES –</b> <b>TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

(continued)

**PLAN F**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> 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
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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
<b>SKILLED NURSING FACILITY CARE*</b> 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 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES –</b> 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
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**PLAN G**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> 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
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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
<b>SKILLED NURSING FACILITY CARE*</b> 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 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES –</b> 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
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY SERVICES –</b> 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
<b>HOME HEALTH CARE</b> 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
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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
<b>SKILLED NURSING FACILITY CARE*</b> 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 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES –</b> 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.
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**PLAN N**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> 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
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> 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.