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. Every Company must make Plan "A" and either Plan C or F available for those eligible for Medicare prior to January 1, 2020 and either Plan D or G available for those eligible for Medicare on or after January 1 2020. Only applicants' **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

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

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

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

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

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY

KENTUCKY Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 402, 410, 416-418

	Preferred				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
0-64	1,768	2,166	1,786	717	1,389
65	1,635	1,913	1,651	664	1,284
66	1,635	1,913	1,651	664	1,284
67	1,635	1,913	1,651	664	1,284
68	1,635	1,989	1,651	664	1,284
69	1,635	2,068	1,651	664	1,284
70	1,700	2,150	1,717	690	1,336
71	1,760	2,226	1,777	713	1,383
72	1,804	2,281	1,822	731	1,417
73	1,848	2,339	1,867	750	1,452
74	1,895	2,396	1,914	769	1,489
75	1,941	2,456	1,961	787	1,525
76	1,990	2,518	2,010	807	1,564
77	2,040	2,581	2,061	827	1,603
78	2,090	2,646	2,112	849	1,643
79	2,143	2,712	2,165	870	1,684
80	2,187	2,766	2,209	887	1,717
81	2,230	2,821	2,253	904	1,751
82	2,274	2,879	2,298	923	1,787
83	2,320	2,935	2,343	942	1,822
84	2,367	2,994	2,390	960	1,860
85	2,401	3,039	2,426	975	1,887
86	2,436	3,084	2,461	989	1,915
87	2,474	3,131	2,499	1,004	1,944
88	2,509	3,177	2,535	1,018	1,973
89	2,548	3,224	2,574	1,035	2,002
90	2,587	3,273	2,613	1,050	2,033
91	2,625	3,323	2,652	1,066	2,063
92	2,665	3,372	2,692	1,082	2,094
93	2,705	3,423	2,732	1,098	2,126
94	2,745	3,475	2,773	1,113	2,157
95	2,786	3,526	2,814	1,131	2,189
96	2,828	3,579	2,857	1,148	2,222
97	2,870	3,633	2,899	1,165	2,255
98	2,913	3,688	2,943	1,183	2,289
99	2,957	3,743	2,986	1,199	2,323

	Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
0-64	2,033	2,492	2,053	825	1,598
65	1,880	2,200	1,899	763	1,478
66	1,880	2,200	1,899	763	1,478
67	1,880	2,200	1,899	763	1,478
68	1,880	2,287	1,899	763	1,478
69	1,880	2,379	1,899	763	1,478
70	1,956	2,474	1,976	793	1,536
71	2,023	2,560	2,043	822	1,590
72	2,074	2,624	2,095	840	1,630
73	2,127	2,689	2,148	862	1,671
74	2,179	2,757	2,201	883	1,713
75	2,233	2,825	2,255	906	1,755
76	2,288	2,894	2,312	930	1,798
77	2,346	2,967	2,369	952	1,844
78	2,403	3,043	2,428	976	1,889
79	2,465	3,118	2,489	1,002	1,937
80	2,514	3,180	2,540	1,020	1,976
81	2,565	3,245	2,591	1,039	2,014
82	2,615	3,311	2,641	1,062	2,054
83	2,669	3,377	2,697	1,083	2,095
84	2,722	3,443	2,749	1,104	2,139
85	2,761	3,495	2,789	1,121	2,170
86	2,802	3,546	2,831	1,137	2,202
87	2,845	3,600	2,873	1,155	2,235
88	2,886	3,653	2,915	1,171	2,269
89	2,932	3,708	2,961	1,189	2,302
90	2,974	3,764	3,005	1,208	2,338
91	3,019	3,821	3,050	1,226	2,373
92	3,065	3,878	3,096	1,245	2,407
93	3,110	3,937	3,141	1,262	2,445
94	3,157	3,996	3,188	1,281	2,480
95	3,205	4,055	3,237	1,301	2,518
96	3,252	4,116	3,285	1,321	2,555
97	3,300	4,180	3,333	1,341	2,593
98	3,349	4,241	3,383	1,359	2,633
99	3,399	4,304	3,433	1,379	2,672

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

KENTUCKY Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 402, 410, 416-418

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,652	2,025	1,669	671	1,298
65	1,528	1,788	1,543	620	1,200
66	1,528	1,788	1,543	620	1,200
67	1,528	1,788	1,543	620	1,200
68	1,528	1,859	1,543	620	1,200
69	1,528	1,933	1,543	620	1,200
70	1,588	2,010	1,605	645	1,249
71	1,645	2,080	1,661	667	1,293
72	1,686	2,132	1,703	683	1,324
73	1,727	2,186	1,745	701	1,357
74	1,771	2,240	1,789	718	1,392
75	1,814	2,296	1,833	736	1,426
76	1,860	2,353	1,879	755	1,462
77	1,906	2,412	1,926	773	1,498
78	1,954	2,473	1,973	793	1,536
79	2,003	2,534	2,023	813	1,574
80	2,044	2,585	2,065	829	1,605
81	2,085	2,637	2,105	845	1,637
82	2,125	2,691	2,147	862	1,670
83	2,168	2,743	2,190	880	1,703
84	2,212	2,798	2,234	898	1,738
85	2,244	2,840	2,267	911	1,763
86	2,277	2,882	2,300	924	1,790
87	2,312	2,926	2,335	938	1,817
88	2,345	2,969	2,369	952	1,844
89	2,382	3,013	2,406	967	1,871
90	2,418	3,059	2,442	981	1,900
91	2,453	3,105	2,478	997	1,928
92	2,490	3,152	2,516	1,011	1,957
93	2,528	3,199	2,553	1,026	1,987
94	2,565	3,247	2,592	1,041	2,016
95	2,604	3,296	2,630	1,057	2,046
96	2,643	3,345	2,670	1,073	2,077
97	2,682	3,396	2,709	1,089	2,108
98	2,723	3,446	2,750	1,106	2,140
99	2,763	3,498	2,791	1,121	2,171

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,900	2,329	1,919	771	1,494
65	1,757	2,056	1,774	713	1,382
66	1,757	2,056	1,774	713	1,382
67	1,757	2,056	1,774	713	1,382
68	1,757	2,137	1,774	713	1,382
69	1,757	2,223	1,774	713	1,382
70	1,828	2,312	1,847	741	1,436
71	1,891	2,393	1,910	768	1,486
72	1,938	2,452	1,958	785	1,524
73	1,988	2,514	2,008	805	1,562
74	2,036	2,576	2,057	825	1,601
75	2,087	2,640	2,108	847	1,640
76	2,138	2,705	2,160	869	1,681
77	2,192	2,773	2,214	890	1,724
78	2,246	2,844	2,269	912	1,766
79	2,303	2,914	2,327	936	1,811
80	2,350	2,972	2,374	954	1,847
81	2,397	3,033	2,421	971	1,882
82	2,444	3,094	2,468	992	1,920
83	2,495	3,156	2,520	1,012	1,958
84	2,544	3,218	2,570	1,032	1,999
85	2,581	3,266	2,607	1,047	2,028
86	2,619	3,314	2,646	1,063	2,058
87	2,659	3,365	2,685	1,079	2,089
88	2,697	3,414	2,725	1,095	2,121
89	2,740	3,465	2,768	1,111	2,152
90	2,780	3,518	2,808	1,129	2,185
91	2,822	3,571	2,850	1,146	2,218
92	2,864	3,625	2,893	1,164	2,250
93	2,906	3,680	2,936	1,179	2,285
94	2,950	3,735	2,980	1,197	2,318
95	2,995	3,790	3,025	1,216	2,353
96	3,039	3,847	3,070	1,234	2,388
97	3,084	3,906	3,115	1,253	2,423
98	3,130	3,963	3,161	1,271	2,461
99	3,177	4,023	3,209	1,289	2,497

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

KENTUCKY Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 402, 410, 416-418

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,572	1,926	1,587	638	1,235
65	1,454	1,700	1,468	590	1,142
66	1,454	1,700	1,468	590	1,142
67	1,454	1,700	1,468	590	1,142
68	1,454	1,768	1,468	590	1,142
69	1,454	1,838	1,468	590	1,142
70	1,511	1,911	1,527	613	1,188
71	1,564	1,979	1,580	634	1,229
72	1,603	2,028	1,620	650	1,259
73	1,643	2,079	1,660	666	1,291
74	1,684	2,130	1,701	683	1,323
75	1,725	2,183	1,743	700	1,356
76	1,769	2,237	1,787	718	1,390
77	1,813	2,294	1,831	736	1,425
78	1,858	2,352	1,877	754	1,461
79	1,906	2,410	1,924	773	1,497
80	1,943	2,459	1,963	789	1,527
81	1,982	2,508	2,002	804	1,557
82	2,022	2,559	2,042	820	1,588
83	2,062	2,609	2,083	837	1,620
84	2,103	2,661	2,124	853	1,653
85	2,135	2,701	2,156	866	1,677
86	2,166	2,741	2,188	879	1,702
87	2,199	2,782	2,221	892	1,728
88	2,232	2,824	2,254	905	1,754
89	2,266	2,866	2,288	919	1,780
90	2,299	2,910	2,322	933	1,807
91	2,334	2,953	2,358	947	1,834
92	2,369	2,998	2,393	962	1,861
93	2,403	3,043	2,428	976	1,889
94	2,440	3,088	2,465	990	1,917
95	2,476	3,134	2,501	1,005	1,946
96	2,513	3,181	2,539	1,020	1,975
97	2,551	3,230	2,576	1,036	2,004
98	2,589	3,278	2,615	1,051	2,035
99	2,627	3,327	2,654	1,066	2,066

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,807	2,215	1,825	733	1,420
65	1,671	1,955	1,688	678	1,314
66	1,671	1,955	1,688	678	1,314
67	1,671	1,955	1,688	678	1,314
68	1,671	2,033	1,688	678	1,314
69	1,671	2,114	1,688	678	1,314
70	1,738	2,199	1,756	705	1,365
71	1,798	2,275	1,816	730	1,414
72	1,843	2,332	1,862	747	1,449
73	1,890	2,390	1,909	766	1,485
74	1,936	2,451	1,956	785	1,522
75	1,984	2,511	2,004	805	1,560
76	2,035	2,573	2,055	826	1,598
77	2,084	2,638	2,106	846	1,640
78	2,137	2,705	2,159	867	1,680
79	2,190	2,772	2,213	890	1,722
80	2,235	2,827	2,257	907	1,756
81	2,279	2,885	2,302	924	1,790
82	2,325	2,943	2,348	944	1,826
83	2,373	3,001	2,396	963	1,862
84	2,419	3,060	2,443	982	1,901
85	2,455	3,106	2,480	996	1,929
86	2,492	3,152	2,516	1,011	1,957
87	2,528	3,200	2,554	1,026	1,987
88	2,566	3,247	2,592	1,040	2,017
89	2,606	3,296	2,632	1,057	2,047
90	2,644	3,346	2,671	1,073	2,077
91	2,684	3,396	2,711	1,090	2,109
92	2,725	3,447	2,752	1,106	2,140
93	2,764	3,499	2,792	1,122	2,173
94	2,806	3,552	2,834	1,138	2,205
95	2,848	3,604	2,877	1,156	2,237
96	2,891	3,658	2,920	1,173	2,272
97	2,933	3,715	2,963	1,191	2,305
98	2,977	3,770	3,007	1,209	2,340
99	3,021	3,826	3,052	1,226	2,375

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

KENTUCKY Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 402, 410, 416-418

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,469	1,800	1,483	596	1,154
65	1,359	1,588	1,372	551	1,067
66	1,359	1,588	1,372	551	1,067
67	1,359	1,588	1,372	551	1,067
68	1,359	1,652	1,372	551	1,067
69	1,359	1,718	1,372	551	1,067
70	1,412	1,786	1,427	573	1,110
71	1,462	1,849	1,476	593	1,148
72	1,498	1,895	1,514	607	1,177
73	1,536	1,943	1,551	623	1,207
74	1,574	1,991	1,590	638	1,236
75	1,613	2,041	1,629	655	1,267
76	1,653	2,091	1,670	671	1,299
77	1,694	2,144	1,712	688	1,332
78	1,737	2,198	1,755	705	1,365
79	1,781	2,253	1,799	723	1,399
80	1,816	2,298	1,835	737	1,427
81	1,852	2,344	1,871	751	1,455
82	1,890	2,391	1,909	767	1,484
83	1,927	2,439	1,947	782	1,514
84	1,966	2,487	1,986	798	1,544
85	1,995	2,525	2,015	810	1,568
86	2,024	2,562	2,045	822	1,591
87	2,055	2,600	2,076	834	1,615
88	2,086	2,639	2,107	846	1,639
89	2,118	2,679	2,138	859	1,663
90	2,148	2,719	2,170	872	1,689
91	2,181	2,760	2,203	886	1,714
92	2,214	2,802	2,236	899	1,739
93	2,246	2,844	2,269	912	1,766
94	2,280	2,886	2,303	925	1,792
95	2,314	2,929	2,338	939	1,818
96	2,349	2,973	2,373	954	1,846
97	2,384	3,018	2,408	968	1,873
98	2,420	3,064	2,444	982	1,902
99	2,455	3,110	2,481	997	1,931

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,689	2,070	1,706	685	1,327
65	1,562	1,827	1,577	634	1,228
66	1,562	1,827	1,577	634	1,228
67	1,562	1,827	1,577	634	1,228
68	1,562	1,900	1,577	634	1,228
69	1,562	1,976	1,577	634	1,228
70	1,625	2,055	1,641	659	1,276
71	1,681	2,126	1,697	682	1,321
72	1,723	2,179	1,740	699	1,354
73	1,767	2,234	1,784	716	1,388
74	1,810	2,290	1,828	734	1,422
75	1,855	2,346	1,873	752	1,458
76	1,902	2,405	1,921	772	1,494
77	1,948	2,465	1,968	791	1,532
78	1,998	2,528	2,017	811	1,570
79	2,047	2,591	2,068	832	1,609
80	2,089	2,642	2,110	848	1,641
81	2,130	2,696	2,152	864	1,673
82	2,173	2,750	2,195	882	1,706
83	2,218	2,805	2,240	900	1,740
84	2,261	2,860	2,284	917	1,777
85	2,295	2,903	2,318	931	1,803
86	2,329	2,946	2,352	945	1,829
87	2,363	2,991	2,387	959	1,857
88	2,398	3,035	2,422	972	1,885
89	2,435	3,080	2,460	988	1,913
90	2,471	3,127	2,496	1,003	1,942
91	2,508	3,174	2,533	1,019	1,971
92	2,547	3,222	2,572	1,034	2,000
93	2,583	3,270	2,609	1,048	2,031
94	2,622	3,320	2,649	1,064	2,060
95	2,662	3,368	2,688	1,080	2,091
96	2,702	3,419	2,729	1,097	2,123
97	2,741	3,472	2,769	1,113	2,154
98	2,782	3,523	2,811	1,130	2,187
99	2,824	3,576	2,852	1,146	2,220

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

Household Discount Factor .93

PREMIUM INFORMATION

ACE Property & Casualty Insurance Company may change your premium on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class. Class is defined as attained age, sex, underwriting class, state of issue, and your most recent zip code of residence in the state of issue. Premiums are based on your attained age and will change on your policy anniversary date.

There is a one-time $25 policy fee.

Household Discount: You are eligible for a household premium discount if 1) you are currently married and residing with your spouse or 2) you have been residing with a person for at least the last 12 months. If you qualify for this discount it will remain in effect for the life of the policy.

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

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 Generally 80%	$0 Generally 20%	$240 (Part B deductible) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 $0 80%	All costs $0 20%	$0 $240 (Part B deductible) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $240 (Part B deductible) $0

PLAN F

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

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

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

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $240 (Part B deductible) Generally 20%	 $0 $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $240 of Medicare Approved amounts* Remainder of Medicare Approved amounts	 $0 $0 80%	 All costs $240 (Part B deductible) 20%	 $0 $0 $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	$0	$0
- First $240 of Medicare Approved Amounts*	$0	$240 (Part B deductible)	$0
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN G

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

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

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

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G
MEDICARE (PART B) – MEDICAL SERVICES-PER – CALENDAR YEAR

*Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 $240 (Unless Part B deductible has been met) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 $240 (Unless Part B deductible has been met) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment - First $240 of Medicare Approved Amounts*	$0	$0	$240 (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE PLAN G
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. **This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE ** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0***
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE ** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 Generally 80%	$0 Generally 20%	$240 (Unless Part B deductible has been met) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $240 of Medicare Approved amounts* Remainder of Medicare Approved amounts	$0 $0 80%	All costs $0 20%	$0 $240 (Unless Part B deductible has been met) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE ** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment - First $240 of Medicare Approved Amounts*	$0	$0	$240 (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE ** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

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

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

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

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $240 of Medicare Approved Amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare Approved Amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment - First $240 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $240 (Part B deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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