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

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

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

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

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

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

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

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

Effective 03-01-2023

ACE PROPERTY & CASUALTY INSURANCE COMPANY

Policy Fee $25

MONTANA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL OF STATE

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
Under 65	6,223	7,710	6,285	2,513	4,950
65	1,556	1,928	1,571	628	1,238
66	1,556	1,928	1,571	628	1,238
67	1,556	1,928	1,571	628	1,238
68	1,556	2,005	1,571	628	1,238
69	1,556	2,085	1,571	628	1,238
70	1,617	2,168	1,634	654	1,287
71	1,674	2,244	1,691	676	1,332
72	1,717	2,299	1,734	693	1,364
73	1,758	2,358	1,776	711	1,399
74	1,803	2,416	1,821	728	1,434
75	1,847	2,475	1,866	746	1,468
76	1,894	2,538	1,913	765	1,505
77	1,941	2,601	1,961	784	1,543
78	1,989	2,666	2,009	804	1,581
79	2,040	2,734	2,060	824	1,622
80	2,081	2,788	2,102	840	1,654
81	2,122	2,844	2,144	857	1,687
82	2,164	2,901	2,186	875	1,721
83	2,208	2,958	2,230	892	1,755
84	2,252	3,017	2,275	909	1,791
85	2,285	3,063	2,308	924	1,818
86	2,318	3,107	2,342	936	1,844
87	2,354	3,154	2,378	951	1,872
88	2,388	3,201	2,412	965	1,900
89	2,425	3,250	2,449	980	1,929
90	2,462	3,297	2,486	995	1,957
91	2,498	3,349	2,523	1,009	1,987
92	2,536	3,399	2,561	1,025	2,017
93	2,574	3,448	2,600	1,039	2,046
94	2,612	3,500	2,639	1,055	2,076
95	2,651	3,553	2,678	1,071	2,108
96	2,691	3,605	2,718	1,086	2,139
97	2,731	3,659	2,759	1,103	2,171
98	2,772	3,715	2,800	1,120	2,204
99	2,813	3,769	2,841	1,137	2,237

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
Under 65	7,155	8,870	7,226	2,894	5,690
65	1,789	2,218	1,807	724	1,422
66	1,789	2,218	1,807	724	1,422
67	1,789	2,218	1,807	724	1,422
68	1,789	2,306	1,807	724	1,422
69	1,789	2,398	1,807	724	1,422
70	1,861	2,493	1,880	753	1,480
71	1,925	2,580	1,944	778	1,531
72	1,973	2,644	1,994	797	1,569
73	2,024	2,710	2,044	818	1,609
74	2,073	2,779	2,094	838	1,650
75	2,125	2,846	2,146	858	1,690
76	2,177	2,919	2,200	879	1,732
77	2,232	2,990	2,255	903	1,774
78	2,287	3,065	2,311	925	1,820
79	2,345	3,144	2,369	948	1,865
80	2,392	3,205	2,417	967	1,903
81	2,440	3,269	2,465	986	1,941
82	2,489	3,336	2,513	1,006	1,979
83	2,540	3,403	2,566	1,026	2,018
84	2,591	3,470	2,616	1,046	2,059
85	2,628	3,524	2,654	1,062	2,090
86	2,667	3,574	2,694	1,077	2,120
87	2,707	3,628	2,734	1,094	2,153
88	2,746	3,681	2,774	1,110	2,185
89	2,790	3,739	2,818	1,127	2,218
90	2,830	3,792	2,859	1,142	2,250
91	2,873	3,851	2,902	1,160	2,285
92	2,916	3,909	2,946	1,178	2,320
93	2,959	3,965	2,989	1,196	2,352
94	3,004	4,025	3,034	1,213	2,389
95	3,050	4,085	3,080	1,232	2,425
96	3,095	4,145	3,126	1,250	2,460
97	3,140	4,209	3,172	1,269	2,498
98	3,186	4,272	3,219	1,288	2,536
99	3,235	4,334	3,267	1,307	2,572

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

Effective 03-01-2023

ACE PROPERTY & CASUALTY INSURANCE COMPANY

Policy Fee $25

MONTANA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL OF STATE

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
Under 65	5,533	6,854	5,587	2,236	4,399
65	1,383	1,714	1,397	559	1,100
66	1,383	1,714	1,397	559	1,100
67	1,383	1,714	1,397	559	1,100
68	1,383	1,782	1,397	559	1,100
69	1,383	1,854	1,397	559	1,100
70	1,438	1,928	1,453	581	1,144
71	1,488	1,995	1,503	601	1,184
72	1,525	2,044	1,541	616	1,213
73	1,564	2,096	1,579	632	1,243
74	1,603	2,148	1,618	647	1,275
75	1,642	2,201	1,659	663	1,306
76	1,683	2,256	1,700	680	1,338
77	1,725	2,312	1,743	697	1,372
78	1,768	2,370	1,786	715	1,407
79	1,813	2,430	1,831	732	1,441
80	1,849	2,477	1,868	747	1,471
81	1,886	2,528	1,905	762	1,500
82	1,924	2,578	1,943	777	1,530
83	1,962	2,630	1,982	793	1,560
84	2,001	2,682	2,022	809	1,592
85	2,032	2,723	2,052	821	1,615
86	2,061	2,762	2,082	832	1,639
87	2,092	2,803	2,113	846	1,663
88	2,124	2,846	2,145	858	1,689
89	2,156	2,890	2,177	871	1,715
90	2,187	2,931	2,210	884	1,739
91	2,221	2,976	2,243	897	1,766
92	2,255	3,022	2,277	911	1,793
93	2,287	3,064	2,311	924	1,819
94	2,322	3,111	2,345	939	1,846
95	2,356	3,158	2,380	952	1,874
96	2,391	3,204	2,416	967	1,902
97	2,427	3,252	2,452	981	1,930
98	2,464	3,302	2,489	996	1,959
99	2,500	3,350	2,526	1,010	1,988

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
Under 65	6,362	7,885	6,424	2,572	5,058
65	1,590	1,971	1,606	643	1,264
66	1,590	1,971	1,606	643	1,264
67	1,590	1,971	1,606	643	1,264
68	1,590	2,050	1,606	643	1,264
69	1,590	2,131	1,606	643	1,264
70	1,654	2,216	1,671	669	1,315
71	1,711	2,294	1,728	692	1,361
72	1,754	2,351	1,772	709	1,394
73	1,799	2,409	1,817	727	1,430
74	1,842	2,470	1,861	745	1,466
75	1,888	2,530	1,907	763	1,502
76	1,936	2,594	1,956	782	1,539
77	1,984	2,658	2,004	802	1,577
78	2,034	2,725	2,054	822	1,617
79	2,084	2,794	2,106	842	1,658
80	2,127	2,849	2,148	859	1,691
81	2,168	2,906	2,191	876	1,725
82	2,212	2,966	2,234	894	1,760
83	2,258	3,024	2,280	912	1,794
84	2,302	3,084	2,325	930	1,830
85	2,336	3,132	2,360	944	1,858
86	2,371	3,176	2,395	958	1,885
87	2,406	3,224	2,430	972	1,913
88	2,442	3,273	2,466	987	1,942
89	2,480	3,323	2,504	1,001	1,971
90	2,516	3,371	2,541	1,016	2,000
91	2,554	3,423	2,579	1,032	2,031
92	2,593	3,474	2,619	1,047	2,062
93	2,630	3,525	2,657	1,063	2,091
94	2,670	3,578	2,697	1,079	2,124
95	2,710	3,631	2,737	1,095	2,155
96	2,751	3,685	2,779	1,111	2,186
97	2,791	3,741	2,819	1,128	2,220
98	2,832	3,797	2,862	1,145	2,253
99	2,875	3,853	2,904	1,161	2,286

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. We will give You advance written notice at least forty-five (45) days prior to any premium change. We will not increase the premiums more frequently than once in a twelve (12) month period.

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

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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.