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.

ACE PROPERTY & CASUALTY INSURANCE COMPANY

INDIANA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 463-464

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	7,393	N/A	N/A	N/A	N/A
65	1,479	1,722	1,493	593	1,131
66	1,479	1,722	1,493	593	1,131
67	1,479	1,722	1,493	593	1,131
68	1,479	1,774	1,493	593	1,131
69	1,485	1,828	1,500	594	1,136
70	1,508	1,883	1,522	603	1,154
71	1,553	1,938	1,568	621	1,188
72	1,607	2,006	1,623	643	1,231
73	1,663	2,076	1,680	665	1,273
74	1,721	2,148	1,738	689	1,318
75	1,790	2,236	1,808	716	1,370
76	1,862	2,324	1,881	746	1,423
77	1,935	2,417	1,955	773	1,481
78	2,013	2,514	2,034	806	1,540
79	2,093	2,615	2,114	838	1,602
80	2,176	2,719	2,200	871	1,666
81	2,274	2,841	2,298	910	1,742
82	2,377	2,968	2,401	950	1,821
83	2,483	3,102	2,509	994	1,903
84	2,595	3,242	2,621	1,038	1,987
85	2,712	3,387	2,739	1,086	2,079
86	2,835	3,539	2,862	1,134	2,172
87	2,960	3,698	2,992	1,185	2,269
88	3,094	3,865	3,126	1,239	2,371
89	3,233	4,039	3,266	1,294	2,478
90	3,378	4,221	3,412	1,353	2,591
91	3,531	4,412	3,567	1,413	2,706
92	3,690	4,610	3,728	1,477	2,829
93	3,856	4,818	3,894	1,542	2,956
94	4,030	5,034	4,070	1,614	3,089
95	4,211	5,261	4,254	1,686	3,228
96	4,400	5,497	4,445	1,762	3,374
97	4,597	5,746	4,645	1,839	3,526
98	4,806	6,005	4,855	1,923	3,686
99	5,022	6,275	5,071	2,009	3,850

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	8,494	N/A	N/A	N/A	N/A
65	1,699	1,980	1,717	681	1,301
66	1,699	1,980	1,717	681	1,301
67	1,699	1,980	1,717	681	1,301
68	1,699	2,040	1,717	681	1,301
69	1,708	2,101	1,726	684	1,308
70	1,734	2,164	1,750	696	1,326
71	1,787	2,230	1,803	714	1,368
72	1,849	2,306	1,867	740	1,415
73	1,912	2,387	1,931	764	1,466
74	1,978	2,472	1,999	792	1,516
75	2,058	2,571	2,078	825	1,576
76	2,140	2,673	2,163	856	1,637
77	2,225	2,779	2,248	891	1,703
78	2,317	2,890	2,338	927	1,773
79	2,408	3,007	2,431	964	1,842
80	2,503	3,126	2,528	1,003	1,915
81	2,616	3,267	2,641	1,048	2,003
82	2,735	3,415	2,759	1,094	2,092
83	2,857	3,568	2,885	1,143	2,189
84	2,984	3,728	3,013	1,194	2,287
85	3,119	3,896	3,151	1,247	2,390
86	3,259	4,070	3,292	1,305	2,498
87	3,405	4,254	3,440	1,363	2,610
88	3,559	4,445	3,594	1,423	2,727
89	3,720	4,645	3,757	1,488	2,850
90	3,885	4,854	3,926	1,557	2,979
91	4,061	5,073	4,101	1,626	3,113
92	4,243	5,301	4,286	1,698	3,252
93	4,436	5,542	4,478	1,774	3,398
94	4,634	5,791	4,681	1,854	3,553
95	4,843	6,051	4,892	1,938	3,712
96	5,060	6,322	5,112	2,026	3,880
97	5,288	6,607	5,341	2,117	4,055
98	5,526	6,905	5,582	2,210	4,238
99	5,775	7,217	5,832	2,311	4,429

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

INDIANA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 463-464

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	6,771	N/A	N/A	N/A	N/A
65	1,354	1,577	1,368	543	1,036
66	1,354	1,577	1,368	543	1,036
67	1,354	1,577	1,368	543	1,036
68	1,354	1,625	1,368	543	1,036
69	1,360	1,675	1,374	544	1,041
70	1,381	1,724	1,394	552	1,057
71	1,422	1,775	1,436	569	1,089
72	1,471	1,838	1,487	589	1,127
73	1,523	1,902	1,538	609	1,166
74	1,576	1,967	1,592	631	1,207
75	1,639	2,048	1,656	655	1,255
76	1,705	2,128	1,723	683	1,304
77	1,772	2,214	1,790	708	1,357
78	1,844	2,302	1,862	738	1,411
79	1,917	2,395	1,937	767	1,468
80	1,993	2,490	2,015	798	1,526
81	2,083	2,602	2,104	834	1,595
82	2,177	2,718	2,199	870	1,667
83	2,274	2,842	2,298	910	1,743
84	2,377	2,969	2,401	951	1,820
85	2,484	3,102	2,509	995	1,904
86	2,596	3,241	2,621	1,039	1,989
87	2,711	3,387	2,740	1,085	2,078
88	2,834	3,540	2,863	1,134	2,172
89	2,961	3,700	2,991	1,185	2,270
90	3,094	3,866	3,125	1,239	2,373
91	3,234	4,041	3,267	1,294	2,479
92	3,379	4,223	3,414	1,352	2,591
93	3,532	4,413	3,567	1,413	2,707
94	3,691	4,611	3,728	1,478	2,829
95	3,857	4,819	3,896	1,544	2,957
96	4,030	5,035	4,071	1,613	3,090
97	4,211	5,263	4,254	1,685	3,230
98	4,402	5,500	4,446	1,761	3,376
99	4,600	5,747	4,645	1,840	3,526

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	7,779	N/A	N/A	N/A	N/A
65	1,556	1,813	1,572	624	1,191
66	1,556	1,813	1,572	624	1,191
67	1,556	1,813	1,572	624	1,191
68	1,556	1,868	1,572	624	1,191
69	1,564	1,924	1,581	627	1,198
70	1,588	1,982	1,603	637	1,215
71	1,637	2,042	1,652	654	1,253
72	1,694	2,112	1,710	678	1,296
73	1,751	2,186	1,769	700	1,342
74	1,812	2,264	1,831	726	1,388
75	1,885	2,354	1,904	755	1,443
76	1,960	2,448	1,981	784	1,499
77	2,037	2,545	2,059	816	1,559
78	2,122	2,647	2,141	849	1,624
79	2,205	2,754	2,227	883	1,687
80	2,293	2,863	2,315	918	1,754
81	2,396	2,992	2,419	960	1,835
82	2,505	3,128	2,527	1,002	1,916
83	2,617	3,268	2,642	1,047	2,005
84	2,733	3,414	2,760	1,094	2,094
85	2,857	3,568	2,886	1,143	2,189
86	2,985	3,727	3,015	1,196	2,288
87	3,119	3,896	3,151	1,249	2,390
88	3,260	4,071	3,292	1,304	2,498
89	3,407	4,254	3,441	1,363	2,610
90	3,558	4,446	3,595	1,426	2,728
91	3,720	4,647	3,756	1,489	2,851
92	3,887	4,855	3,926	1,555	2,978
93	4,062	5,076	4,102	1,625	3,113
94	4,245	5,304	4,287	1,698	3,254
95	4,436	5,542	4,480	1,775	3,400
96	4,635	5,790	4,682	1,856	3,554
97	4,844	6,051	4,892	1,939	3,714
98	5,062	6,324	5,112	2,024	3,881
99	5,289	6,610	5,342	2,117	4,056

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

INDIANA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 463-464

	Preferred				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
0-64	6,572	N/A	N/A	N/A	N/A
65	1,314	1,530	1,328	526	1,006
66	1,314	1,530	1,328	526	1,006
67	1,314	1,530	1,328	526	1,006
68	1,314	1,577	1,328	526	1,006
69	1,320	1,625	1,334	529	1,009
70	1,339	1,674	1,354	537	1,026
71	1,381	1,724	1,394	552	1,057
72	1,429	1,783	1,443	572	1,094
73	1,479	1,845	1,493	592	1,132
74	1,530	1,910	1,545	612	1,171
75	1,591	1,987	1,607	637	1,217
76	1,654	2,066	1,671	662	1,265
77	1,720	2,148	1,738	689	1,316
78	1,790	2,235	1,808	716	1,369
79	1,861	2,324	1,880	746	1,423
80	1,935	2,417	1,954	773	1,480
81	2,021	2,525	2,043	809	1,548
82	2,112	2,638	2,134	846	1,618
83	2,208	2,758	2,229	884	1,691
84	2,307	2,881	2,329	923	1,768
85	2,411	3,011	2,435	965	1,847
86	2,520	3,146	2,544	1,008	1,931
87	2,631	3,287	2,659	1,054	2,018
88	2,750	3,435	2,778	1,102	2,108
89	2,875	3,590	2,903	1,151	2,203
90	3,003	3,751	3,035	1,203	2,301
91	3,139	3,922	3,171	1,256	2,405
92	3,279	4,098	3,312	1,313	2,514
93	3,428	4,282	3,463	1,371	2,627
94	3,582	4,476	3,619	1,433	2,746
95	3,744	4,676	3,781	1,498	2,869
96	3,911	4,886	3,950	1,566	2,999
97	4,087	5,107	4,129	1,636	3,134
98	4,272	5,337	4,314	1,709	3,276
99	4,463	5,577	4,507	1,786	3,423

	Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
0-64	7,556	N/A	N/A	N/A	N/A
65	1,511	1,759	1,527	605	1,156
66	1,511	1,759	1,527	605	1,156
67	1,511	1,759	1,527	605	1,156
68	1,511	1,813	1,527	605	1,156
69	1,518	1,868	1,534	608	1,162
70	1,540	1,924	1,556	616	1,180
71	1,589	1,983	1,603	635	1,215
72	1,643	2,050	1,659	657	1,259
73	1,700	2,122	1,717	680	1,302
74	1,758	2,197	1,776	703	1,346
75	1,829	2,285	1,848	733	1,400
76	1,902	2,376	1,922	761	1,457
77	1,978	2,470	1,999	792	1,515
78	2,058	2,569	2,078	823	1,575
79	2,140	2,673	2,163	856	1,637
80	2,225	2,779	2,247	891	1,703
81	2,323	2,904	2,348	930	1,780
82	2,429	3,035	2,454	971	1,861
83	2,539	3,171	2,564	1,015	1,945
84	2,653	3,314	2,680	1,060	2,033
85	2,773	3,463	2,800	1,109	2,125
86	2,896	3,618	2,926	1,161	2,221
87	3,027	3,781	3,057	1,212	2,320
88	3,163	3,949	3,195	1,265	2,424
89	3,306	4,128	3,339	1,322	2,534
90	3,454	4,314	3,490	1,382	2,648
91	3,610	4,510	3,646	1,444	2,766
92	3,772	4,713	3,810	1,510	2,890
93	3,942	4,925	3,982	1,577	3,021
94	4,120	5,147	4,161	1,648	3,158
95	4,304	5,378	4,348	1,724	3,301
96	4,498	5,620	4,543	1,801	3,449
97	4,700	5,872	4,748	1,882	3,604
98	4,913	6,138	4,961	1,965	3,767
99	5,132	6,414	5,184	2,054	3,937

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

INDIANA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 463-464

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	6,020	N/A	N/A	N/A	N/A
65	1,204	1,401	1,216	482	921
66	1,204	1,401	1,216	482	921
67	1,204	1,401	1,216	482	921
68	1,204	1,444	1,216	482	921
69	1,209	1,488	1,221	484	924
70	1,227	1,533	1,240	492	940
71	1,265	1,579	1,277	506	968
72	1,309	1,633	1,321	524	1,002
73	1,354	1,690	1,368	542	1,037
74	1,401	1,749	1,415	561	1,072
75	1,457	1,820	1,471	583	1,115
76	1,515	1,893	1,530	606	1,159
77	1,575	1,967	1,592	631	1,206
78	1,639	2,047	1,656	655	1,254
79	1,704	2,128	1,722	683	1,304
80	1,772	2,214	1,789	708	1,356
81	1,851	2,313	1,871	741	1,418
82	1,935	2,417	1,954	775	1,482
83	2,022	2,526	2,042	809	1,549
84	2,113	2,639	2,133	845	1,620
85	2,208	2,758	2,230	884	1,692
86	2,308	2,881	2,330	923	1,768
87	2,410	3,011	2,436	965	1,848
88	2,519	3,146	2,545	1,009	1,930
89	2,633	3,288	2,659	1,054	2,018
90	2,751	3,436	2,779	1,102	2,108
91	2,875	3,592	2,904	1,151	2,202
92	3,004	3,754	3,033	1,203	2,302
93	3,139	3,922	3,171	1,256	2,406
94	3,280	4,099	3,314	1,313	2,515
95	3,429	4,283	3,463	1,372	2,627
96	3,582	4,475	3,618	1,434	2,747
97	3,744	4,677	3,782	1,498	2,870
98	3,912	4,888	3,951	1,565	3,001
99	4,087	5,108	4,128	1,636	3,135

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	6,920	N/A	N/A	N/A	N/A
65	1,384	1,611	1,398	554	1,059
66	1,384	1,611	1,398	554	1,059
67	1,384	1,611	1,398	554	1,059
68	1,384	1,660	1,398	554	1,059
69	1,390	1,711	1,405	556	1,064
70	1,411	1,762	1,425	565	1,080
71	1,455	1,816	1,468	582	1,113
72	1,504	1,877	1,520	601	1,153
73	1,557	1,944	1,572	623	1,192
74	1,610	2,012	1,627	644	1,233
75	1,675	2,092	1,693	672	1,282
76	1,742	2,176	1,761	697	1,334
77	1,812	2,263	1,831	726	1,387
78	1,885	2,353	1,904	754	1,442
79	1,960	2,448	1,981	784	1,499
80	2,037	2,545	2,058	816	1,559
81	2,128	2,660	2,151	852	1,631
82	2,225	2,779	2,247	890	1,704
83	2,326	2,905	2,348	930	1,782
84	2,429	3,035	2,454	971	1,862
85	2,540	3,172	2,564	1,016	1,947
86	2,653	3,313	2,680	1,063	2,034
87	2,772	3,463	2,800	1,110	2,125
88	2,897	3,617	2,926	1,159	2,220
89	3,028	3,781	3,058	1,211	2,321
90	3,163	3,951	3,196	1,266	2,426
91	3,306	4,131	3,339	1,323	2,534
92	3,454	4,316	3,489	1,383	2,647
93	3,611	4,511	3,647	1,444	2,767
94	3,773	4,714	3,811	1,509	2,892
95	3,942	4,926	3,982	1,579	3,023
96	4,120	5,147	4,161	1,649	3,159
97	4,304	5,378	4,349	1,723	3,301
98	4,500	5,622	4,544	1,800	3,450
99	4,700	5,875	4,748	1,881	3,606

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.

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.

NOTE: The policy fee is fully refundable if the policy is not issued, delivery of the policy is refused or the policy is returned with the policy's 30-day free look period.

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.