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)			80%	80%				80%	80%	80%	80%	
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

NEW MEXICO Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 871

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
65	1,429	1,672	1,443	578	1,103
66	1,429	1,672	1,443	578	1,103
67	1,429	1,672	1,443	578	1,103
68	1,429	1,718	1,443	578	1,109
69	1,436	1,769	1,450	580	1,124
70	1,455	1,822	1,469	588	1,145
71	1,498	1,877	1,514	605	1,179
72	1,551	1,942	1,566	626	1,220
73	1,605	2,011	1,621	649	1,262
74	1,661	2,080	1,677	671	1,307
75	1,728	2,163	1,745	697	1,359
76	1,797	2,250	1,815	726	1,413
77	1,868	2,340	1,887	755	1,470
78	1,943	2,434	1,962	785	1,529
79	2,020	2,531	2,041	816	1,590
80	2,101	2,632	2,123	849	1,653
81	2,195	2,751	2,218	887	1,728
82	2,295	2,874	2,317	926	1,805
83	2,398	3,003	2,422	969	1,887
84	2,505	3,138	2,530	1,012	1,972
85	2,618	3,279	2,645	1,058	2,061
86	2,736	3,427	2,763	1,106	2,154
87	2,859	3,581	2,887	1,155	2,250
88	2,987	3,742	3,018	1,206	2,351
89	3,122	3,910	3,154	1,261	2,457
90	3,262	4,086	3,296	1,319	2,568
91	3,409	4,271	3,443	1,378	2,683
92	3,563	4,463	3,599	1,439	2,805
93	3,723	4,664	3,760	1,504	2,931
94	3,890	4,874	3,929	1,572	3,063
95	4,066	5,093	4,106	1,643	3,201
96	4,248	5,322	4,291	1,716	3,345
97	4,439	5,563	4,484	1,794	3,496
98	4,640	5,813	4,686	1,874	3,654
99	4,848	6,074	4,897	1,959	3,818

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
65	1,643	1,923	1,659	665	1,269
66	1,643	1,923	1,659	665	1,269
67	1,643	1,923	1,659	665	1,269
68	1,643	1,975	1,659	665	1,275
69	1,651	2,034	1,668	668	1,293
70	1,674	2,096	1,690	676	1,317
71	1,724	2,158	1,741	696	1,356
72	1,784	2,233	1,801	721	1,403
73	1,845	2,312	1,863	745	1,452
74	1,910	2,392	1,929	772	1,502
75	1,986	2,489	2,006	802	1,562
76	2,066	2,587	2,087	835	1,625
77	2,148	2,691	2,170	868	1,690
78	2,234	2,798	2,257	903	1,759
79	2,324	2,911	2,347	939	1,827
80	2,417	3,027	2,441	976	1,901
81	2,525	3,163	2,550	1,021	1,986
82	2,638	3,305	2,665	1,066	2,075
83	2,757	3,453	2,785	1,114	2,170
84	2,881	3,608	2,910	1,164	2,267
85	3,010	3,771	3,041	1,216	2,369
86	3,147	3,941	3,178	1,272	2,477
87	3,287	4,119	3,321	1,328	2,587
88	3,435	4,304	3,470	1,389	2,704
89	3,590	4,497	3,626	1,450	2,827
90	3,751	4,700	3,790	1,517	2,953
91	3,921	4,912	3,959	1,584	3,087
92	4,097	5,134	4,138	1,656	3,225
93	4,281	5,364	4,324	1,730	3,371
94	4,474	5,605	4,519	1,807	3,522
95	4,676	5,858	4,722	1,889	3,681
96	4,886	6,120	4,934	1,974	3,847
97	5,105	6,396	5,157	2,063	4,021
98	5,335	6,684	5,389	2,155	4,201
99	5,576	6,985	5,632	2,253	4,391

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

NEW MEXICO Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 871

	Preferred						Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,294	1,514	1,307	523	999	65	1,488	1,741	1,502	602	1,149
66	1,294	1,514	1,307	523	999	66	1,488	1,741	1,502	602	1,149
67	1,294	1,514	1,307	523	999	67	1,488	1,741	1,502	602	1,149
68	1,294	1,556	1,307	523	1,004	68	1,488	1,788	1,502	602	1,155
69	1,301	1,602	1,313	525	1,018	69	1,496	1,842	1,511	605	1,171
70	1,318	1,650	1,331	533	1,037	70	1,516	1,898	1,530	612	1,192
71	1,356	1,700	1,371	548	1,068	71	1,561	1,955	1,576	631	1,228
72	1,404	1,759	1,418	567	1,105	72	1,616	2,023	1,631	653	1,271
73	1,453	1,821	1,468	588	1,143	73	1,671	2,094	1,688	675	1,315
74	1,504	1,884	1,519	608	1,184	74	1,730	2,167	1,747	699	1,360
75	1,565	1,959	1,580	632	1,231	75	1,799	2,254	1,816	727	1,415
76	1,627	2,038	1,644	658	1,280	76	1,871	2,343	1,890	756	1,472
77	1,692	2,120	1,709	684	1,332	77	1,945	2,437	1,965	786	1,530
78	1,760	2,204	1,777	711	1,384	78	2,024	2,534	2,044	818	1,593
79	1,830	2,292	1,848	739	1,440	79	2,104	2,636	2,125	851	1,655
80	1,903	2,384	1,923	769	1,497	80	2,189	2,742	2,211	884	1,721
81	1,988	2,491	2,008	804	1,565	81	2,287	2,865	2,310	924	1,799
82	2,078	2,603	2,099	839	1,635	82	2,389	2,993	2,413	966	1,880
83	2,172	2,720	2,194	877	1,709	83	2,497	3,128	2,522	1,009	1,965
84	2,268	2,842	2,292	917	1,786	84	2,609	3,268	2,635	1,054	2,053
85	2,371	2,969	2,395	958	1,866	85	2,726	3,416	2,754	1,101	2,146
86	2,478	3,104	2,503	1,001	1,951	86	2,850	3,569	2,878	1,152	2,244
87	2,589	3,243	2,615	1,046	2,038	87	2,977	3,731	3,008	1,203	2,343
88	2,705	3,389	2,733	1,092	2,129	88	3,111	3,898	3,143	1,258	2,449
89	2,827	3,541	2,856	1,142	2,225	89	3,252	4,072	3,284	1,313	2,560
90	2,954	3,701	2,985	1,194	2,326	90	3,397	4,257	3,432	1,374	2,675
91	3,087	3,868	3,118	1,248	2,430	91	3,551	4,449	3,586	1,434	2,796
92	3,227	4,042	3,259	1,304	2,540	92	3,710	4,649	3,748	1,500	2,920
93	3,372	4,224	3,405	1,362	2,654	93	3,877	4,858	3,916	1,567	3,053
94	3,523	4,414	3,559	1,424	2,774	94	4,052	5,076	4,092	1,637	3,190
95	3,683	4,613	3,719	1,488	2,899	95	4,235	5,305	4,277	1,711	3,334
96	3,848	4,820	3,886	1,554	3,030	96	4,425	5,543	4,469	1,788	3,484
97	4,020	5,038	4,061	1,624	3,166	97	4,623	5,793	4,670	1,868	3,641
98	4,202	5,265	4,244	1,697	3,309	98	4,832	6,054	4,881	1,952	3,804
99	4,391	5,501	4,435	1,774	3,458	99	5,050	6,326	5,100	2,040	3,976

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

NEW MEXICO Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 871

	Preferred						Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,270	1,486	1,284	513	981	65	1,461	1,709	1,476	590	1,128
66	1,270	1,486	1,284	513	981	66	1,461	1,709	1,476	590	1,128
67	1,270	1,486	1,284	513	981	67	1,461	1,709	1,476	590	1,128
68	1,270	1,526	1,284	513	987	68	1,461	1,755	1,476	590	1,134
69	1,276	1,572	1,289	515	999	69	1,468	1,808	1,483	594	1,149
70	1,293	1,620	1,306	523	1,018	70	1,487	1,862	1,502	601	1,170
71	1,332	1,668	1,345	537	1,047	71	1,532	1,919	1,547	619	1,205
72	1,378	1,726	1,392	558	1,084	72	1,586	1,985	1,601	640	1,247
73	1,427	1,787	1,441	577	1,123	73	1,640	2,054	1,657	663	1,290
74	1,477	1,850	1,491	597	1,162	74	1,697	2,126	1,714	686	1,336
75	1,535	1,924	1,551	620	1,207	75	1,766	2,212	1,783	713	1,389
76	1,596	2,000	1,613	646	1,256	76	1,836	2,300	1,855	742	1,445
77	1,660	2,080	1,677	671	1,306	77	1,909	2,392	1,929	772	1,502
78	1,727	2,163	1,745	697	1,359	78	1,986	2,488	2,006	802	1,562
79	1,796	2,250	1,814	726	1,413	79	2,066	2,587	2,086	834	1,625
80	1,868	2,339	1,887	755	1,469	80	2,148	2,691	2,169	868	1,690
81	1,951	2,444	1,972	789	1,535	81	2,244	2,811	2,267	907	1,766
82	2,039	2,555	2,060	824	1,605	82	2,346	2,938	2,369	948	1,845
83	2,131	2,669	2,152	861	1,677	83	2,451	3,070	2,475	990	1,928
84	2,227	2,789	2,249	900	1,753	84	2,561	3,208	2,586	1,035	2,016
85	2,328	2,915	2,350	940	1,832	85	2,677	3,353	2,703	1,081	2,106
86	2,432	3,045	2,456	983	1,914	86	2,796	3,503	2,825	1,130	2,202
87	2,541	3,183	2,567	1,027	2,000	87	2,922	3,661	2,952	1,181	2,300
88	2,655	3,326	2,683	1,073	2,090	88	3,054	3,824	3,085	1,234	2,404
89	2,775	3,476	2,803	1,121	2,185	89	3,191	3,997	3,223	1,289	2,512
90	2,900	3,633	2,929	1,171	2,282	90	3,335	4,177	3,369	1,347	2,626
91	3,031	3,796	3,060	1,224	2,385	91	3,485	4,366	3,520	1,408	2,743
92	3,166	3,968	3,198	1,279	2,493	92	3,641	4,562	3,678	1,471	2,866
93	3,309	4,146	3,342	1,337	2,605	93	3,806	4,768	3,844	1,537	2,996
94	3,458	4,332	3,493	1,397	2,723	94	3,976	4,982	4,017	1,607	3,131
95	3,614	4,527	3,651	1,461	2,845	95	4,156	5,207	4,198	1,679	3,272
96	3,776	4,731	3,814	1,525	2,973	96	4,343	5,440	4,386	1,754	3,420
97	3,946	4,944	3,987	1,594	3,107	97	4,538	5,686	4,583	1,834	3,573
98	4,124	5,166	4,166	1,666	3,247	98	4,742	5,941	4,790	1,916	3,734
99	4,309	5,399	4,352	1,742	3,394	99	4,956	6,209	5,005	2,002	3,903

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

NEW MEXICO Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 871

	Preferred						Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,150	1,346	1,163	465	888	65	1,323	1,548	1,336	535	1,021
66	1,150	1,346	1,163	465	888	66	1,323	1,548	1,336	535	1,021
67	1,150	1,346	1,163	465	888	67	1,323	1,548	1,336	535	1,021
68	1,150	1,382	1,163	465	894	68	1,323	1,590	1,336	535	1,027
69	1,156	1,424	1,167	467	904	69	1,330	1,638	1,343	538	1,041
70	1,171	1,467	1,183	473	922	70	1,347	1,687	1,360	544	1,060
71	1,207	1,511	1,218	487	948	71	1,387	1,738	1,401	561	1,092
72	1,248	1,563	1,260	505	982	72	1,436	1,798	1,450	580	1,129
73	1,292	1,619	1,305	522	1,017	73	1,485	1,860	1,500	600	1,168
74	1,337	1,675	1,351	540	1,052	74	1,537	1,926	1,552	621	1,210
75	1,390	1,742	1,404	562	1,093	75	1,599	2,004	1,615	646	1,258
76	1,446	1,812	1,461	585	1,138	76	1,663	2,083	1,680	672	1,308
77	1,503	1,884	1,519	608	1,183	77	1,729	2,167	1,747	699	1,360
78	1,564	1,959	1,580	632	1,231	78	1,799	2,253	1,816	727	1,415
79	1,626	2,038	1,643	658	1,280	79	1,871	2,343	1,889	756	1,472
80	1,692	2,119	1,709	684	1,331	80	1,945	2,437	1,964	786	1,530
81	1,767	2,214	1,786	714	1,390	81	2,032	2,546	2,053	822	1,599
82	1,847	2,314	1,865	746	1,453	82	2,124	2,661	2,146	858	1,671
83	1,930	2,417	1,949	780	1,519	83	2,220	2,780	2,242	897	1,746
84	2,017	2,526	2,037	815	1,588	84	2,319	2,905	2,342	937	1,826
85	2,108	2,640	2,128	852	1,659	85	2,424	3,036	2,448	979	1,908
86	2,202	2,758	2,224	890	1,734	86	2,532	3,173	2,558	1,023	1,994
87	2,301	2,883	2,325	930	1,812	87	2,647	3,316	2,674	1,069	2,083
88	2,405	3,012	2,430	972	1,893	88	2,766	3,464	2,794	1,117	2,177
89	2,513	3,148	2,538	1,016	1,979	89	2,890	3,620	2,919	1,167	2,275
90	2,627	3,290	2,652	1,061	2,067	90	3,020	3,783	3,051	1,220	2,378
91	2,745	3,438	2,772	1,109	2,160	91	3,156	3,954	3,188	1,275	2,484
92	2,868	3,593	2,896	1,159	2,258	92	3,298	4,132	3,331	1,332	2,596
93	2,997	3,755	3,027	1,211	2,360	93	3,447	4,318	3,481	1,392	2,713
94	3,132	3,924	3,163	1,265	2,466	94	3,601	4,512	3,638	1,455	2,836
95	3,273	4,100	3,306	1,323	2,577	95	3,764	4,716	3,802	1,521	2,964
96	3,420	4,284	3,454	1,381	2,693	96	3,933	4,927	3,972	1,589	3,097
97	3,574	4,477	3,611	1,444	2,814	97	4,110	5,149	4,151	1,661	3,236
98	3,735	4,679	3,773	1,509	2,940	98	4,295	5,381	4,338	1,736	3,382
99	3,902	4,889	3,942	1,577	3,074	99	4,488	5,624	4,533	1,813	3,535

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. You will be given at least sixty (60) days advance written notice if a new table of rates is applicable to 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.

NOTICE: If you are in an open enrollment period or otherwise qualify for a guaranteed issue policy, the above paragraph does not apply to you. The Company shall not discriminate in the pricing of this Medicare Supplement policy because of health status, claims experience, receipt of health care or medical condition.

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*	$0	$0	$240 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare Approved amounts*	$0	$0	$240 (Unless Part B deductible has been met)
Remainder of Medicare Approved amounts	80%	20%	$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.