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 2025[2]						$7220[2]	$3610[2]					

[1]Plans F and G also have a high deductible option which requires first paying a plan deductible of $2870 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 AND CASUALTY INSURANCE COMPANY

Policy Fee $25

NEVADA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 889-891

	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	1,870	2,207	1,905	756	1,401	65	2,149	2,539	2,190	869	1,610
66	1,870	2,207	1,905	756	1,401	66	2,149	2,539	2,190	869	1,610
67	1,870	2,207	1,905	756	1,401	67	2,149	2,539	2,190	869	1,610
68	1,870	2,268	1,905	756	1,408	68	2,149	2,608	2,190	869	1,618
69	1,879	2,336	1,915	758	1,426	69	2,161	2,686	2,203	874	1,641
70	1,904	2,406	1,940	770	1,454	70	2,190	2,766	2,231	885	1,671
71	1,960	2,478	1,999	792	1,497	71	2,255	2,849	2,298	911	1,721
72	2,029	2,564	2,067	819	1,547	72	2,334	2,948	2,378	943	1,781
73	2,100	2,654	2,140	848	1,602	73	2,414	3,052	2,461	975	1,843
74	2,173	2,745	2,214	878	1,658	74	2,498	3,158	2,547	1,010	1,906
75	2,260	2,856	2,303	913	1,725	75	2,599	3,287	2,648	1,049	1,983
76	2,350	2,972	2,396	950	1,793	76	2,703	3,416	2,756	1,093	2,062
77	2,443	3,091	2,491	987	1,865	77	2,809	3,554	2,864	1,136	2,144
78	2,542	3,213	2,590	1,027	1,940	78	2,924	3,695	2,980	1,181	2,231
79	2,643	3,343	2,694	1,068	2,018	79	3,039	3,843	3,099	1,228	2,318
80	2,748	3,476	2,804	1,111	2,096	80	3,162	3,997	3,224	1,277	2,412
81	2,872	3,632	2,927	1,160	2,192	81	3,303	4,177	3,367	1,336	2,522
82	3,002	3,794	3,059	1,212	2,290	82	3,452	4,364	3,519	1,395	2,634
83	3,136	3,965	3,198	1,268	2,394	83	3,607	4,560	3,676	1,457	2,754
84	3,277	4,143	3,340	1,324	2,502	84	3,770	4,764	3,842	1,523	2,877
85	3,425	4,329	3,492	1,384	2,615	85	3,938	4,980	4,016	1,590	3,007
86	3,579	4,525	3,648	1,447	2,733	86	4,117	5,204	4,196	1,664	3,143
87	3,740	4,728	3,813	1,512	2,855	87	4,300	5,438	4,385	1,738	3,284
88	3,908	4,940	3,984	1,579	2,983	88	4,494	5,682	4,582	1,817	3,431
89	4,084	5,163	4,164	1,650	3,118	89	4,696	5,936	4,788	1,897	3,587
90	4,266	5,395	4,351	1,725	3,259	90	4,908	6,206	5,003	1,984	3,746
91	4,459	5,639	4,546	1,803	3,404	91	5,130	6,486	5,227	2,072	3,917
92	4,661	5,892	4,752	1,884	3,559	92	5,360	6,779	5,464	2,166	4,092
93	4,870	6,158	4,964	1,968	3,719	93	5,601	7,082	5,709	2,263	4,278
94	5,089	6,436	5,188	2,057	3,887	94	5,853	7,401	5,967	2,364	4,470
95	5,319	6,725	5,422	2,149	4,062	95	6,117	7,734	6,235	2,471	4,672
96	5,558	7,027	5,666	2,245	4,245	96	6,392	8,081	6,515	2,582	4,881
97	5,808	7,345	5,920	2,346	4,436	97	6,678	8,445	6,809	2,698	5,102
98	6,069	7,675	6,187	2,452	4,637	98	6,980	8,825	7,116	2,820	5,331
99	6,343	8,019	6,466	2,563	4,845	99	7,294	9,223	7,436	2,947	5,572

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

ACE PROPERTY AND CASUALTY INSURANCE COMPANY

NEVADA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 889-891

	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	1,660	1,959	1,691	671	1,244	65	1,908	2,254	1,945	772	1,429
66	1,660	1,959	1,691	671	1,244	66	1,908	2,254	1,945	772	1,429
67	1,660	1,959	1,691	671	1,244	67	1,908	2,254	1,945	772	1,429
68	1,660	2,014	1,691	671	1,250	68	1,908	2,315	1,945	772	1,436
69	1,668	2,074	1,700	673	1,266	69	1,919	2,385	1,956	776	1,457
70	1,691	2,136	1,722	683	1,291	70	1,944	2,456	1,981	786	1,484
71	1,740	2,200	1,775	703	1,329	71	2,002	2,530	2,040	808	1,528
72	1,802	2,276	1,835	727	1,374	72	2,073	2,618	2,111	837	1,581
73	1,864	2,357	1,900	753	1,422	73	2,143	2,710	2,185	866	1,636
74	1,929	2,438	1,965	780	1,472	74	2,218	2,804	2,262	897	1,692
75	2,007	2,536	2,045	811	1,532	75	2,307	2,918	2,351	932	1,761
76	2,087	2,638	2,127	843	1,592	76	2,400	3,033	2,447	971	1,830
77	2,169	2,744	2,212	876	1,656	77	2,494	3,155	2,543	1,009	1,903
78	2,257	2,853	2,300	912	1,723	78	2,596	3,280	2,646	1,049	1,981
79	2,346	2,968	2,392	948	1,791	79	2,698	3,412	2,751	1,091	2,058
80	2,440	3,086	2,489	986	1,861	80	2,807	3,549	2,862	1,134	2,141
81	2,550	3,225	2,599	1,030	1,946	81	2,932	3,708	2,989	1,186	2,239
82	2,666	3,368	2,716	1,076	2,034	82	3,065	3,875	3,124	1,238	2,338
83	2,785	3,521	2,839	1,126	2,126	83	3,202	4,049	3,264	1,294	2,445
84	2,910	3,678	2,966	1,176	2,221	84	3,347	4,230	3,411	1,352	2,555
85	3,041	3,844	3,100	1,229	2,322	85	3,497	4,422	3,565	1,412	2,670
86	3,178	4,018	3,239	1,285	2,426	86	3,656	4,620	3,726	1,477	2,791
87	3,320	4,198	3,385	1,342	2,535	87	3,818	4,829	3,893	1,543	2,916
88	3,470	4,386	3,537	1,402	2,648	88	3,990	5,045	4,068	1,613	3,046
89	3,626	4,584	3,697	1,465	2,768	89	4,170	5,271	4,251	1,685	3,185
90	3,788	4,790	3,863	1,532	2,893	90	4,357	5,510	4,442	1,762	3,326
91	3,959	5,007	4,036	1,601	3,023	91	4,554	5,758	4,641	1,840	3,478
92	4,138	5,231	4,219	1,672	3,160	92	4,759	6,018	4,851	1,923	3,633
93	4,324	5,467	4,407	1,747	3,302	93	4,973	6,288	5,069	2,009	3,798
94	4,519	5,714	4,606	1,826	3,451	94	5,197	6,571	5,298	2,099	3,969
95	4,723	5,971	4,814	1,908	3,606	95	5,431	6,866	5,536	2,194	4,148
96	4,935	6,239	5,030	1,994	3,768	96	5,675	7,175	5,784	2,292	4,334
97	5,157	6,522	5,256	2,083	3,939	97	5,929	7,498	6,045	2,396	4,530
98	5,389	6,815	5,493	2,177	4,117	98	6,197	7,836	6,318	2,503	4,733
99	5,632	7,120	5,741	2,276	4,302	99	6,476	8,189	6,602	2,616	4,947

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

ACE PROPERTY AND CASUALTY INSURANCE COMPANY

NEVADA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 889-891

	Preferred				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
65	1,662	1,962	1,695	671	1,243
66	1,662	1,962	1,695	671	1,243
67	1,662	1,962	1,695	671	1,243
68	1,662	2,015	1,695	671	1,253
69	1,670	2,076	1,702	674	1,268
70	1,692	2,139	1,724	684	1,291
71	1,743	2,203	1,776	703	1,329
72	1,803	2,279	1,838	729	1,375
73	1,866	2,359	1,902	755	1,424
74	1,932	2,442	1,969	781	1,475
75	2,008	2,540	2,048	811	1,532
76	2,088	2,641	2,130	845	1,594
77	2,171	2,745	2,214	878	1,657
78	2,259	2,856	2,303	913	1,725
79	2,349	2,972	2,394	950	1,793
80	2,443	3,088	2,491	987	1,864
81	2,553	3,227	2,603	1,032	1,948
82	2,668	3,373	2,720	1,077	2,037
83	2,787	3,525	2,841	1,126	2,129
84	2,913	3,682	2,969	1,178	2,225
85	3,045	3,849	3,102	1,230	2,324
86	3,181	4,021	3,242	1,285	2,429
87	3,324	4,203	3,389	1,344	2,538
88	3,474	4,392	3,542	1,403	2,653
89	3,631	4,589	3,701	1,468	2,772
90	3,794	4,796	3,867	1,532	2,896
91	3,965	5,012	4,040	1,602	3,028
92	4,142	5,239	4,222	1,673	3,163
93	4,329	5,473	4,413	1,748	3,306
94	4,523	5,720	4,612	1,828	3,455
95	4,728	5,977	4,820	1,911	3,610
96	4,939	6,247	5,036	1,996	3,773
97	5,163	6,528	5,264	2,086	3,943
98	5,395	6,822	5,500	2,179	4,120
99	5,637	7,128	5,746	2,279	4,307

	Standard				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
65	1,911	2,256	1,948	772	1,431
66	1,911	2,256	1,948	772	1,431
67	1,911	2,256	1,948	772	1,431
68	1,911	2,317	1,948	772	1,440
69	1,921	2,387	1,958	777	1,457
70	1,946	2,459	1,983	786	1,485
71	2,004	2,533	2,042	810	1,530
72	2,074	2,622	2,113	838	1,582
73	2,145	2,713	2,188	867	1,636
74	2,220	2,807	2,263	897	1,694
75	2,310	2,920	2,354	934	1,762
76	2,401	3,037	2,449	971	1,833
77	2,497	3,158	2,547	1,010	1,906
78	2,599	3,284	2,648	1,049	1,983
79	2,703	3,416	2,755	1,091	2,062
80	2,809	3,554	2,863	1,136	2,144
81	2,935	3,711	2,994	1,187	2,241
82	3,069	3,879	3,128	1,240	2,342
83	3,206	4,053	3,268	1,295	2,446
84	3,350	4,235	3,415	1,353	2,558
85	3,501	4,427	3,569	1,414	2,672
86	3,659	4,626	3,730	1,478	2,794
87	3,823	4,834	3,898	1,545	2,919
88	3,995	5,050	4,073	1,614	3,051
89	4,174	5,278	4,256	1,686	3,188
90	4,362	5,515	4,448	1,762	3,333
91	4,560	5,765	4,648	1,842	3,481
92	4,763	6,024	4,856	1,925	3,638
93	4,979	6,296	5,075	2,011	3,801
94	5,201	6,578	5,304	2,102	3,973
95	5,437	6,874	5,542	2,197	4,152
96	5,681	7,182	5,792	2,295	4,339
97	5,936	7,507	6,052	2,399	4,535
98	6,204	7,845	6,325	2,508	4,738
99	6,483	8,199	6,608	2,620	4,953

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

ACE PROPERTY AND CASUALTY INSURANCE COMPANY

NEVADA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 889-891

	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	1,475	1,742	1,505	596	1,104	65	1,697	2,003	1,729	685	1,270
66	1,475	1,742	1,505	596	1,104	66	1,697	2,003	1,729	685	1,270
67	1,475	1,742	1,505	596	1,104	67	1,697	2,003	1,729	685	1,270
68	1,475	1,789	1,505	596	1,112	68	1,697	2,058	1,729	685	1,278
69	1,483	1,843	1,511	598	1,126	69	1,705	2,120	1,739	689	1,294
70	1,502	1,899	1,530	607	1,146	70	1,728	2,183	1,760	698	1,318
71	1,547	1,956	1,577	624	1,180	71	1,779	2,249	1,813	719	1,358
72	1,601	2,023	1,632	647	1,221	72	1,842	2,328	1,876	744	1,405
73	1,657	2,095	1,689	670	1,264	73	1,904	2,409	1,943	770	1,453
74	1,715	2,168	1,748	694	1,309	74	1,971	2,492	2,009	796	1,504
75	1,783	2,255	1,818	720	1,360	75	2,051	2,593	2,090	829	1,565
76	1,854	2,344	1,891	750	1,415	76	2,132	2,696	2,175	862	1,627
77	1,928	2,438	1,965	780	1,471	77	2,217	2,804	2,262	897	1,692
78	2,006	2,536	2,045	811	1,532	78	2,307	2,916	2,351	932	1,761
79	2,086	2,638	2,126	843	1,592	79	2,400	3,033	2,446	969	1,830
80	2,169	2,742	2,212	876	1,655	80	2,494	3,155	2,542	1,009	1,903
81	2,266	2,865	2,311	916	1,730	81	2,606	3,295	2,658	1,054	1,989
82	2,369	2,995	2,415	956	1,809	82	2,725	3,444	2,777	1,101	2,080
83	2,475	3,129	2,522	999	1,890	83	2,846	3,598	2,901	1,150	2,172
84	2,587	3,269	2,636	1,045	1,975	84	2,974	3,760	3,032	1,201	2,272
85	2,704	3,417	2,754	1,092	2,063	85	3,109	3,931	3,169	1,256	2,372
86	2,825	3,570	2,879	1,141	2,157	86	3,248	4,107	3,312	1,312	2,481
87	2,951	3,732	3,009	1,193	2,253	87	3,394	4,292	3,461	1,372	2,592
88	3,084	3,900	3,145	1,246	2,356	88	3,547	4,484	3,616	1,433	2,709
89	3,224	4,075	3,286	1,303	2,461	89	3,706	4,686	3,779	1,497	2,831
90	3,368	4,258	3,434	1,360	2,571	90	3,873	4,897	3,949	1,565	2,959
91	3,520	4,450	3,587	1,422	2,688	91	4,049	5,118	4,126	1,635	3,090
92	3,677	4,651	3,749	1,486	2,808	92	4,229	5,348	4,312	1,709	3,230
93	3,843	4,860	3,918	1,552	2,935	93	4,421	5,590	4,505	1,785	3,375
94	4,016	5,078	4,094	1,623	3,068	94	4,618	5,840	4,709	1,866	3,527
95	4,197	5,307	4,280	1,697	3,205	95	4,827	6,103	4,921	1,950	3,686
96	4,385	5,546	4,471	1,772	3,350	96	5,044	6,377	5,142	2,038	3,853
97	4,584	5,796	4,673	1,852	3,501	97	5,271	6,666	5,373	2,130	4,026
98	4,790	6,057	4,883	1,935	3,658	98	5,509	6,965	5,616	2,226	4,207
99	5,005	6,329	5,102	2,023	3,824	99	5,756	7,280	5,867	2,326	4,397

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.

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 $1676	$0	$1676 (Part A deductible)
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	$0	Up to $209.50 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 $257 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 $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 $257 (Part B deductible) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 $257 (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 $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $257 (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 $1676	$1676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 $257 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 $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $257 (Part B deductible) Generally 20%	 $0 $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $257 of Medicare Approved amounts* Remainder of Medicare Approved amounts	 $0 $0 80%	 All costs $257 (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	100%	$0	$0
Durable medical equipment - First $257 of Medicare Approved Amounts*	$0	$257 (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 $1676	$1676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 $257 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 $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 $257 (Unless Part B deductible has been met) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 $257 (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 $257 of Medicare Approved Amounts*	$0	$0	$257 (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 $2870 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2870. 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 $2870 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2870 DEDUCTIBLE ** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1676	$1676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 $257 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 $2870 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2870. 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 $2870 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2870 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 $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 Generally 80%	$0 Generally 20%	$257 (Unless Part B deductible has been met) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $257 of Medicare Approved amounts* Remainder of Medicare Approved amounts	$0 $0 80%	All costs $0 20%	$0 $257 (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 $2870 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2870 DEDUCTIBLE ** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment - First $257 of Medicare Approved Amounts*	$0	$0	$257 (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 $2870 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2870 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 $1676	$1676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 $257 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 $257 of Medicare Approved Amounts*	$0	$0	$257 (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 $257 of Medicare Approved Amounts*	$0	$0	$257 (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 $257 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $257 (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.