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

IOWA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 515

	Preferred				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,330	1,573	1,343	533	1,027
66	1,330	1,573	1,343	533	1,027
67	1,330	1,573	1,343	533	1,027
68	1,330	1,616	1,343	533	1,032
69	1,337	1,664	1,350	535	1,047
70	1,355	1,714	1,368	543	1,067
71	1,395	1,766	1,409	558	1,098
72	1,444	1,827	1,458	578	1,137
73	1,494	1,892	1,509	598	1,176
74	1,547	1,956	1,561	619	1,217
75	1,609	2,035	1,625	643	1,266
76	1,673	2,117	1,690	670	1,316
77	1,739	2,202	1,757	696	1,370
78	1,809	2,290	1,827	724	1,423
79	1,881	2,381	1,900	753	1,481
80	1,956	2,476	1,977	783	1,540
81	2,044	2,588	2,065	818	1,609
82	2,137	2,703	2,158	854	1,681
83	2,233	2,825	2,255	894	1,758
84	2,332	2,951	2,356	934	1,837
85	2,438	3,084	2,463	976	1,919
86	2,547	3,224	2,573	1,020	2,006
87	2,662	3,369	2,689	1,066	2,096
88	2,781	3,520	2,810	1,113	2,190
89	2,907	3,679	2,936	1,163	2,289
90	3,037	3,844	3,069	1,216	2,392
91	3,174	4,018	3,206	1,271	2,499
92	3,317	4,198	3,351	1,328	2,612
93	3,466	4,387	3,501	1,387	2,730
94	3,622	4,585	3,659	1,450	2,854
95	3,786	4,791	3,824	1,515	2,982
96	3,956	5,006	3,995	1,583	3,117
97	4,134	5,233	4,175	1,654	3,256
98	4,320	5,469	4,364	1,728	3,403
99	4,515	5,714	4,560	1,807	3,557

	Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,530	1,809	1,545	613	1,182
66	1,530	1,809	1,545	613	1,182
67	1,530	1,809	1,545	613	1,182
68	1,530	1,857	1,545	613	1,188
69	1,538	1,913	1,554	616	1,204
70	1,558	1,972	1,573	624	1,226
71	1,605	2,030	1,621	642	1,263
72	1,661	2,101	1,677	665	1,307
73	1,718	2,175	1,735	687	1,353
74	1,779	2,250	1,796	712	1,399
75	1,850	2,341	1,867	740	1,456
76	1,924	2,434	1,943	770	1,513
77	2,000	2,532	2,020	801	1,574
78	2,081	2,633	2,101	833	1,638
79	2,164	2,738	2,185	866	1,702
80	2,250	2,848	2,273	900	1,770
81	2,351	2,976	2,375	941	1,851
82	2,457	3,109	2,481	983	1,934
83	2,567	3,249	2,593	1,027	2,021
84	2,683	3,394	2,709	1,073	2,112
85	2,803	3,548	2,832	1,121	2,206
86	2,930	3,707	2,959	1,173	2,307
87	3,061	3,875	3,092	1,225	2,410
88	3,199	4,048	3,231	1,281	2,519
89	3,343	4,230	3,377	1,337	2,634
90	3,493	4,422	3,529	1,399	2,751
91	3,651	4,621	3,686	1,461	2,875
92	3,815	4,829	3,853	1,527	3,003
93	3,986	5,045	4,026	1,595	3,140
94	4,166	5,273	4,208	1,667	3,281
95	4,354	5,511	4,397	1,742	3,429
96	4,549	5,757	4,594	1,820	3,583
97	4,753	6,017	4,802	1,902	3,745
98	4,968	6,288	5,018	1,987	3,913
99	5,192	6,571	5,244	2,077	4,089

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

IOWA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 515

	Preferred				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,260	1,489	1,272	504	973
66	1,260	1,489	1,272	504	973
67	1,260	1,489	1,272	504	973
68	1,260	1,530	1,272	504	977
69	1,266	1,575	1,278	506	991
70	1,283	1,623	1,295	514	1,010
71	1,320	1,672	1,334	529	1,039
72	1,367	1,730	1,380	547	1,076
73	1,415	1,791	1,429	566	1,113
74	1,464	1,852	1,478	586	1,152
75	1,523	1,927	1,538	609	1,199
76	1,584	2,004	1,600	634	1,246
77	1,647	2,084	1,663	659	1,297
78	1,713	2,168	1,730	686	1,348
79	1,781	2,255	1,799	713	1,402
80	1,852	2,345	1,872	741	1,458
81	1,935	2,450	1,955	775	1,524
82	2,023	2,559	2,043	809	1,592
83	2,114	2,675	2,135	846	1,664
84	2,208	2,794	2,231	884	1,739
85	2,308	2,920	2,332	924	1,817
86	2,412	3,053	2,436	965	1,899
87	2,520	3,190	2,546	1,009	1,984
88	2,633	3,333	2,661	1,053	2,073
89	2,752	3,483	2,780	1,101	2,167
90	2,875	3,639	2,905	1,151	2,265
91	3,005	3,804	3,035	1,203	2,366
92	3,141	3,975	3,173	1,257	2,473
93	3,282	4,154	3,315	1,313	2,585
94	3,430	4,341	3,464	1,373	2,702
95	3,585	4,536	3,620	1,435	2,823
96	3,745	4,740	3,783	1,499	2,951
97	3,914	4,955	3,953	1,566	3,083
98	4,090	5,178	4,131	1,636	3,222
99	4,274	5,410	4,317	1,711	3,367

	Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,448	1,712	1,462	580	1,119
66	1,448	1,712	1,462	580	1,119
67	1,448	1,712	1,462	580	1,119
68	1,448	1,759	1,462	580	1,125
69	1,456	1,811	1,471	583	1,140
70	1,476	1,867	1,490	591	1,161
71	1,519	1,922	1,534	608	1,196
72	1,573	1,989	1,588	629	1,238
73	1,627	2,059	1,643	651	1,281
74	1,684	2,131	1,701	674	1,325
75	1,751	2,217	1,768	701	1,378
76	1,821	2,305	1,840	729	1,433
77	1,893	2,397	1,913	758	1,490
78	1,970	2,493	1,990	789	1,551
79	2,048	2,593	2,069	820	1,611
80	2,131	2,696	2,152	852	1,676
81	2,226	2,818	2,248	891	1,752
82	2,326	2,943	2,349	931	1,831
83	2,431	3,076	2,455	973	1,913
84	2,540	3,214	2,565	1,016	1,999
85	2,654	3,359	2,681	1,062	2,089
86	2,775	3,510	2,802	1,111	2,184
87	2,898	3,669	2,928	1,160	2,282
88	3,029	3,833	3,060	1,213	2,385
89	3,165	4,005	3,197	1,266	2,494
90	3,307	4,186	3,341	1,325	2,605
91	3,457	4,375	3,490	1,383	2,722
92	3,612	4,572	3,648	1,446	2,843
93	3,774	4,777	3,812	1,511	2,973
94	3,945	4,993	3,984	1,578	3,106
95	4,122	5,218	4,163	1,649	3,247
96	4,307	5,451	4,350	1,723	3,392
97	4,501	5,697	4,546	1,801	3,546
98	4,703	5,953	4,751	1,882	3,705
99	4,915	6,222	4,965	1,967	3,872

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

IOWA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 515

	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	1,182	1,398	1,195	473	913	65	1,360	1,607	1,374	545	1,051
66	1,182	1,398	1,195	473	913	66	1,360	1,607	1,374	545	1,051
67	1,182	1,398	1,195	473	913	67	1,360	1,607	1,374	545	1,051
68	1,182	1,436	1,195	473	919	68	1,360	1,651	1,374	545	1,057
69	1,188	1,479	1,200	475	930	69	1,367	1,701	1,381	547	1,070
70	1,204	1,524	1,216	482	948	70	1,385	1,752	1,399	554	1,090
71	1,241	1,569	1,253	496	976	71	1,426	1,805	1,440	571	1,122
72	1,283	1,624	1,296	514	1,010	72	1,477	1,867	1,490	590	1,161
73	1,329	1,681	1,341	532	1,046	73	1,527	1,933	1,543	611	1,201
74	1,375	1,740	1,389	550	1,082	74	1,580	2,000	1,596	633	1,244
75	1,429	1,810	1,444	572	1,124	75	1,644	2,081	1,660	658	1,293
76	1,486	1,882	1,502	595	1,170	76	1,709	2,163	1,727	684	1,346
77	1,546	1,956	1,561	619	1,216	77	1,778	2,250	1,796	712	1,399
78	1,608	2,035	1,625	643	1,266	78	1,850	2,340	1,867	740	1,456
79	1,672	2,117	1,689	670	1,316	79	1,924	2,434	1,942	769	1,513
80	1,739	2,201	1,757	696	1,369	80	2,000	2,532	2,019	801	1,574
81	1,817	2,299	1,836	727	1,429	81	2,089	2,644	2,111	837	1,645
82	1,899	2,403	1,918	760	1,495	82	2,184	2,764	2,206	874	1,719
83	1,984	2,510	2,004	794	1,562	83	2,282	2,888	2,305	913	1,796
84	2,074	2,624	2,094	830	1,634	84	2,385	3,018	2,408	954	1,878
85	2,167	2,742	2,188	867	1,706	85	2,492	3,154	2,517	997	1,962
86	2,264	2,864	2,287	906	1,783	86	2,604	3,295	2,630	1,042	2,051
87	2,366	2,994	2,391	947	1,863	87	2,721	3,444	2,749	1,089	2,143
88	2,472	3,129	2,498	989	1,947	88	2,844	3,598	2,872	1,138	2,240
89	2,584	3,270	2,610	1,034	2,035	89	2,971	3,760	3,001	1,189	2,340
90	2,700	3,418	2,727	1,080	2,126	90	3,105	3,930	3,137	1,243	2,446
91	2,822	3,571	2,849	1,129	2,222	91	3,245	4,107	3,278	1,298	2,555
92	2,948	3,732	2,978	1,180	2,323	92	3,390	4,292	3,425	1,357	2,670
93	3,081	3,900	3,112	1,233	2,427	93	3,544	4,485	3,579	1,418	2,790
94	3,220	4,076	3,252	1,288	2,537	94	3,702	4,687	3,741	1,482	2,917
95	3,365	4,258	3,399	1,347	2,650	95	3,870	4,898	3,909	1,549	3,048
96	3,516	4,450	3,551	1,407	2,770	96	4,044	5,118	4,084	1,618	3,185
97	3,675	4,650	3,712	1,470	2,894	97	4,225	5,348	4,268	1,691	3,329
98	3,840	4,860	3,879	1,537	3,025	98	4,416	5,589	4,460	1,768	3,478
99	4,012	5,079	4,053	1,606	3,162	99	4,614	5,841	4,661	1,847	3,636

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

IOWA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 515

	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	1,120	1,324	1,132	448	865	65	1,288	1,522	1,301	516	995
66	1,120	1,324	1,132	448	865	66	1,288	1,522	1,301	516	995
67	1,120	1,324	1,132	448	865	67	1,288	1,522	1,301	516	995
68	1,120	1,360	1,132	448	870	68	1,288	1,563	1,301	516	1,001
69	1,125	1,400	1,136	450	880	69	1,294	1,611	1,307	518	1,014
70	1,140	1,443	1,151	456	898	70	1,311	1,659	1,324	525	1,032
71	1,175	1,486	1,186	469	924	71	1,350	1,709	1,363	541	1,063
72	1,215	1,537	1,227	487	956	72	1,398	1,768	1,411	559	1,100
73	1,258	1,592	1,270	504	990	73	1,446	1,830	1,461	579	1,138
74	1,302	1,648	1,315	521	1,025	74	1,496	1,894	1,511	599	1,178
75	1,353	1,713	1,367	541	1,064	75	1,557	1,971	1,572	623	1,225
76	1,407	1,782	1,422	564	1,108	76	1,619	2,048	1,635	648	1,275
77	1,463	1,852	1,478	586	1,151	77	1,683	2,131	1,701	674	1,325
78	1,522	1,927	1,538	609	1,199	78	1,751	2,216	1,768	701	1,378
79	1,583	2,004	1,599	634	1,246	79	1,821	2,305	1,839	728	1,433
80	1,647	2,084	1,663	659	1,296	80	1,893	2,397	1,912	758	1,490
81	1,720	2,177	1,738	689	1,353	81	1,978	2,504	1,999	792	1,558
82	1,798	2,275	1,816	719	1,415	82	2,068	2,617	2,089	827	1,627
83	1,878	2,377	1,897	752	1,479	83	2,161	2,734	2,182	865	1,700
84	1,963	2,484	1,983	786	1,547	84	2,258	2,857	2,280	903	1,778
85	2,052	2,596	2,072	821	1,615	85	2,360	2,986	2,383	944	1,858
86	2,144	2,712	2,165	858	1,688	86	2,465	3,120	2,490	987	1,942
87	2,240	2,835	2,263	897	1,764	87	2,576	3,261	2,603	1,031	2,029
88	2,341	2,963	2,365	937	1,844	88	2,692	3,406	2,719	1,077	2,121
89	2,447	3,096	2,471	979	1,927	89	2,813	3,560	2,842	1,126	2,216
90	2,557	3,236	2,582	1,023	2,013	90	2,940	3,721	2,970	1,176	2,316
91	2,672	3,381	2,698	1,069	2,104	91	3,073	3,888	3,103	1,229	2,420
92	2,791	3,534	2,819	1,117	2,199	92	3,210	4,063	3,243	1,285	2,528
93	2,918	3,692	2,946	1,167	2,298	93	3,356	4,247	3,388	1,342	2,642
94	3,048	3,859	3,079	1,220	2,402	94	3,505	4,437	3,542	1,403	2,762
95	3,186	4,032	3,218	1,275	2,509	95	3,664	4,637	3,701	1,466	2,886
96	3,329	4,213	3,362	1,332	2,622	96	3,829	4,846	3,867	1,532	3,016
97	3,479	4,403	3,515	1,392	2,740	97	4,001	5,064	4,041	1,601	3,152
98	3,636	4,601	3,673	1,455	2,864	98	4,181	5,292	4,223	1,673	3,293
99	3,799	4,808	3,837	1,521	2,993	99	4,369	5,530	4,413	1,748	3,442

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 $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.