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

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

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

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

Effective 08-01-2023

ACE PROPERTY & CASUALTY INSURANCE COMPANY

Policy Fee $25

OHIO Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 436, 440-445, 450-454

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
65	1,554	1,784	1,569	623	1,197
66	1,554	1,784	1,569	623	1,197
67	1,554	1,784	1,569	623	1,197
68	1,554	1,837	1,569	626	1,214
69	1,554	1,892	1,569	633	1,244
70	1,600	1,957	1,616	645	1,275
71	1,648	2,025	1,665	664	1,313
72	1,705	2,106	1,724	687	1,359
73	1,765	2,190	1,784	711	1,407
74	1,835	2,279	1,855	735	1,456
75	1,910	2,369	1,930	765	1,515
76	1,986	2,463	2,007	795	1,575
77	2,065	2,561	2,087	827	1,638
78	2,147	2,665	2,171	860	1,704
79	2,234	2,770	2,257	894	1,773
80	2,323	2,867	2,347	925	1,834
81	2,415	2,968	2,442	958	1,898
82	2,512	3,072	2,540	991	1,966
83	2,612	3,180	2,641	1,025	2,034
84	2,703	3,292	2,734	1,062	2,104
85	2,798	3,406	2,828	1,098	2,178
86	2,896	3,509	2,927	1,138	2,253
87	2,997	3,614	3,031	1,177	2,333
88	3,103	3,722	3,136	1,219	2,414
89	3,212	3,833	3,247	1,256	2,487
90	3,325	3,949	3,361	1,292	2,561
91	3,425	4,068	3,463	1,331	2,638
92	3,527	4,189	3,566	1,371	2,717
93	3,634	4,294	3,673	1,412	2,799
94	3,743	4,402	3,783	1,456	2,884
95	3,855	4,512	3,897	1,499	2,970
96	3,970	4,625	4,013	1,544	3,059
97	4,089	4,740	4,134	1,591	3,152
98	4,213	4,859	4,257	1,639	3,245
99	4,338	4,981	4,385	1,688	3,344

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
65	1,786	2,052	1,804	715	1,377
66	1,786	2,052	1,804	715	1,377
67	1,786	2,052	1,804	715	1,377
68	1,786	2,112	1,804	721	1,397
69	1,786	2,175	1,804	728	1,430
70	1,841	2,251	1,860	742	1,466
71	1,894	2,329	1,915	763	1,510
72	1,961	2,422	1,983	790	1,563
73	2,031	2,519	2,052	817	1,617
74	2,111	2,620	2,134	846	1,675
75	2,196	2,725	2,219	881	1,742
76	2,284	2,833	2,307	914	1,812
77	2,374	2,946	2,401	951	1,884
78	2,470	3,064	2,496	989	1,960
79	2,570	3,186	2,596	1,029	2,037
80	2,671	3,297	2,700	1,064	2,110
81	2,777	3,413	2,808	1,101	2,184
82	2,888	3,533	2,921	1,140	2,261
83	3,004	3,658	3,036	1,180	2,339
84	3,109	3,786	3,143	1,220	2,421
85	3,218	3,918	3,253	1,262	2,504
86	3,331	4,035	3,367	1,309	2,592
87	3,447	4,156	3,485	1,353	2,682
88	3,568	4,280	3,607	1,401	2,777
89	3,694	4,408	3,734	1,444	2,860
90	3,823	4,542	3,865	1,486	2,946
91	3,938	4,679	3,982	1,530	3,034
92	4,057	4,819	4,100	1,578	3,125
93	4,178	4,938	4,224	1,625	3,220
94	4,304	5,061	4,350	1,675	3,316
95	4,434	5,189	4,481	1,724	3,415
96	4,567	5,318	4,616	1,776	3,519
97	4,704	5,450	4,754	1,829	3,624
98	4,845	5,588	4,896	1,885	3,733
99	4,990	5,727	5,042	1,941	3,845

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY

OHIO Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 436, 440-445, 450-454

	Preferred				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,451	1,666	1,466	582	1,118
66	1,451	1,666	1,466	582	1,118
67	1,451	1,666	1,466	582	1,118
68	1,451	1,715	1,466	585	1,134
69	1,451	1,767	1,466	591	1,161
70	1,495	1,828	1,509	602	1,191
71	1,539	1,891	1,555	620	1,226
72	1,593	1,967	1,610	641	1,269
73	1,649	2,046	1,666	664	1,314
74	1,714	2,128	1,733	687	1,360
75	1,784	2,213	1,802	715	1,415
76	1,854	2,300	1,874	742	1,471
77	1,928	2,392	1,949	772	1,530
78	2,005	2,489	2,028	803	1,592
79	2,086	2,587	2,108	835	1,656
80	2,169	2,678	2,192	864	1,713
81	2,256	2,772	2,281	895	1,773
82	2,346	2,869	2,372	926	1,836
83	2,440	2,970	2,467	958	1,900
84	2,525	3,074	2,553	992	1,966
85	2,613	3,181	2,641	1,025	2,034
86	2,705	3,277	2,734	1,063	2,105
87	2,799	3,375	2,831	1,100	2,179
88	2,898	3,476	2,929	1,139	2,255
89	3,000	3,580	3,032	1,173	2,323
90	3,105	3,688	3,139	1,207	2,392
91	3,199	3,799	3,234	1,243	2,464
92	3,294	3,912	3,331	1,281	2,538
93	3,394	4,010	3,430	1,319	2,614
94	3,496	4,111	3,533	1,360	2,693
95	3,601	4,214	3,639	1,400	2,774
96	3,708	4,319	3,748	1,442	2,857
97	3,819	4,427	3,861	1,486	2,944
98	3,935	4,538	3,976	1,531	3,031
99	4,052	4,652	4,096	1,576	3,123

	Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,668	1,916	1,685	668	1,286
66	1,668	1,916	1,685	668	1,286
67	1,668	1,916	1,685	668	1,286
68	1,668	1,973	1,685	673	1,305
69	1,668	2,031	1,685	680	1,335
70	1,719	2,102	1,737	693	1,369
71	1,769	2,176	1,789	712	1,411
72	1,832	2,262	1,852	738	1,460
73	1,897	2,353	1,917	763	1,510
74	1,972	2,447	1,993	790	1,564
75	2,051	2,545	2,073	823	1,627
76	2,133	2,646	2,155	854	1,693
77	2,217	2,751	2,242	889	1,760
78	2,307	2,861	2,332	924	1,831
79	2,400	2,976	2,424	961	1,903
80	2,495	3,080	2,522	994	1,971
81	2,594	3,188	2,623	1,029	2,040
82	2,698	3,300	2,728	1,065	2,112
83	2,806	3,416	2,836	1,102	2,185
84	2,903	3,536	2,936	1,140	2,261
85	3,005	3,659	3,038	1,179	2,338
86	3,111	3,768	3,144	1,222	2,421
87	3,219	3,882	3,255	1,263	2,505
88	3,333	3,997	3,369	1,309	2,594
89	3,450	4,117	3,488	1,349	2,671
90	3,571	4,242	3,610	1,388	2,751
91	3,678	4,370	3,719	1,429	2,833
92	3,789	4,500	3,830	1,473	2,919
93	3,902	4,612	3,945	1,518	3,007
94	4,020	4,727	4,062	1,564	3,097
95	4,141	4,846	4,185	1,610	3,190
96	4,265	4,967	4,311	1,659	3,286
97	4,393	5,090	4,440	1,708	3,384
98	4,525	5,219	4,573	1,761	3,486
99	4,660	5,349	4,709	1,813	3,591

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

OHIO Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 436, 440-445, 450-454

	Preferred				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,381	1,585	1,395	553	1,064
66	1,381	1,585	1,395	553	1,064
67	1,381	1,585	1,395	553	1,064
68	1,381	1,633	1,395	557	1,079
69	1,381	1,681	1,395	562	1,106
70	1,422	1,740	1,437	573	1,133
71	1,465	1,800	1,480	590	1,167
72	1,516	1,872	1,533	611	1,208
73	1,569	1,947	1,586	632	1,250
74	1,632	2,025	1,649	654	1,294
75	1,697	2,106	1,715	680	1,346
76	1,765	2,189	1,784	707	1,400
77	1,835	2,276	1,855	735	1,456
78	1,909	2,368	1,930	764	1,515
79	1,986	2,463	2,007	795	1,575
80	2,065	2,549	2,087	822	1,630
81	2,147	2,638	2,170	851	1,688
82	2,233	2,731	2,257	881	1,747
83	2,322	2,827	2,347	912	1,808
84	2,403	2,926	2,430	944	1,871
85	2,488	3,028	2,514	976	1,936
86	2,574	3,119	2,602	1,011	2,003
87	2,665	3,212	2,693	1,046	2,074
88	2,758	3,308	2,788	1,084	2,146
89	2,855	3,408	2,886	1,116	2,210
90	2,955	3,510	2,987	1,149	2,276
91	3,044	3,616	3,077	1,183	2,345
92	3,135	3,724	3,170	1,219	2,415
93	3,230	3,817	3,264	1,256	2,488
94	3,327	3,912	3,362	1,294	2,563
95	3,427	4,011	3,464	1,333	2,640
96	3,529	4,111	3,567	1,372	2,720
97	3,635	4,213	3,674	1,414	2,801
98	3,744	4,319	3,784	1,457	2,885
99	3,857	4,427	3,898	1,500	2,972

	Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,588	1,823	1,604	636	1,224
66	1,588	1,823	1,604	636	1,224
67	1,588	1,823	1,604	636	1,224
68	1,588	1,877	1,604	640	1,241
69	1,588	1,934	1,604	647	1,271
70	1,636	2,001	1,653	659	1,303
71	1,684	2,070	1,703	678	1,343
72	1,743	2,153	1,763	702	1,389
73	1,805	2,239	1,824	726	1,438
74	1,877	2,329	1,897	752	1,488
75	1,952	2,422	1,972	783	1,548
76	2,030	2,518	2,051	812	1,611
77	2,110	2,618	2,134	846	1,675
78	2,195	2,723	2,219	879	1,742
79	2,284	2,832	2,307	914	1,811
80	2,374	2,931	2,400	946	1,875
81	2,469	3,034	2,496	979	1,941
82	2,568	3,141	2,596	1,013	2,010
83	2,670	3,251	2,699	1,048	2,079
84	2,764	3,365	2,794	1,085	2,152
85	2,860	3,482	2,892	1,122	2,226
86	2,961	3,586	2,993	1,163	2,304
87	3,064	3,694	3,097	1,203	2,384
88	3,172	3,804	3,207	1,246	2,468
89	3,283	3,919	3,319	1,283	2,542
90	3,398	4,037	3,436	1,321	2,618
91	3,500	4,158	3,539	1,360	2,696
92	3,606	4,283	3,645	1,402	2,778
93	3,714	4,389	3,754	1,444	2,862
94	3,825	4,499	3,867	1,488	2,948
95	3,941	4,612	3,983	1,532	3,036
96	4,059	4,727	4,103	1,579	3,128
97	4,180	4,845	4,225	1,626	3,221
98	4,306	4,967	4,352	1,676	3,318
99	4,435	5,091	4,482	1,725	3,417

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

OHIO Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 436, 440-445, 450-454

	Preferred				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,290	1,481	1,302	517	994
66	1,290	1,481	1,302	517	994
67	1,290	1,481	1,302	517	994
68	1,290	1,525	1,302	520	1,008
69	1,290	1,570	1,302	525	1,033
70	1,328	1,625	1,342	535	1,058
71	1,368	1,681	1,383	551	1,090
72	1,416	1,748	1,431	570	1,128
73	1,466	1,818	1,481	590	1,168
74	1,524	1,891	1,541	611	1,209
75	1,585	1,967	1,602	635	1,257
76	1,649	2,045	1,666	660	1,308
77	1,714	2,126	1,733	687	1,360
78	1,783	2,212	1,802	714	1,415
79	1,854	2,300	1,874	742	1,471
80	1,928	2,380	1,949	768	1,523
81	2,005	2,464	2,027	795	1,576
82	2,085	2,550	2,108	823	1,632
83	2,168	2,640	2,192	851	1,689
84	2,244	2,733	2,269	881	1,747
85	2,323	2,828	2,348	911	1,808
86	2,404	2,913	2,430	944	1,871
87	2,489	3,000	2,516	977	1,937
88	2,576	3,090	2,604	1,012	2,005
89	2,666	3,182	2,695	1,042	2,064
90	2,760	3,278	2,790	1,073	2,126
91	2,843	3,377	2,874	1,105	2,190
92	2,928	3,478	2,960	1,139	2,256
93	3,017	3,564	3,049	1,173	2,324
94	3,107	3,654	3,140	1,209	2,394
95	3,201	3,746	3,235	1,245	2,466
96	3,296	3,839	3,332	1,282	2,540
97	3,395	3,935	3,431	1,321	2,616
98	3,497	4,034	3,534	1,361	2,694
99	3,602	4,135	3,640	1,401	2,776

	Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,483	1,703	1,498	594	1,143
66	1,483	1,703	1,498	594	1,143
67	1,483	1,703	1,498	594	1,143
68	1,483	1,753	1,498	598	1,159
69	1,483	1,806	1,498	604	1,187
70	1,528	1,869	1,544	616	1,217
71	1,573	1,934	1,590	633	1,254
72	1,628	2,011	1,647	656	1,297
73	1,686	2,091	1,704	679	1,343
74	1,753	2,176	1,771	702	1,390
75	1,823	2,262	1,842	731	1,446
76	1,896	2,352	1,916	759	1,504
77	1,971	2,445	1,993	790	1,564
78	2,050	2,543	2,073	821	1,627
79	2,133	2,645	2,155	854	1,692
80	2,217	2,738	2,241	883	1,751
81	2,306	2,833	2,332	914	1,813
82	2,398	2,933	2,424	946	1,877
83	2,494	3,036	2,521	979	1,942
84	2,581	3,142	2,609	1,013	2,010
85	2,672	3,253	2,701	1,048	2,079
86	2,765	3,349	2,795	1,086	2,152
87	2,862	3,450	2,893	1,123	2,227
88	2,963	3,553	2,995	1,163	2,305
89	3,067	3,660	3,100	1,198	2,374
90	3,174	3,770	3,209	1,233	2,445
91	3,269	3,884	3,306	1,271	2,518
92	3,368	4,000	3,404	1,310	2,595
93	3,469	4,099	3,506	1,349	2,673
94	3,573	4,202	3,611	1,390	2,753
95	3,681	4,308	3,720	1,431	2,836
96	3,791	4,415	3,832	1,474	2,921
97	3,904	4,525	3,946	1,519	3,008
98	4,022	4,639	4,064	1,565	3,099
99	4,142	4,755	4,186	1,611	3,192

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

Household Discount Factor .93

PREMIUM INFORMATION

We, ACE Property & Casualty Insurance Company can only raise your premium if we raise the premium for all policies like yours in this State. Premiums are based on your attained age and will change on your policy anniversary date.

PREFERRED AND STANDARD PREMIUMS

Preferred and Standard premiums are shown on the premium charts. You are eligible for Preferred premiums if:

1. You apply for your Medicare Supplement insurance policy during the 6-month open enrollment period that begins on your Part B date
2. You apply for your Medicare Supplement insurance policy during your eligible guaranteed issue period, or
3. Your answer is “no” to the question on the application that asks, “Have you used tobacco in any form, including cigarettes, vapes, nicotine gum or patches, chewing tobacco, pipes, or eCigarettes in the past twelve (12) months?”

HOUSEHOLD PREMIUM DISCOUNT

You are eligible for a household premium discount if, for the past year, you have resided with one other Medicare-eligible adult who owns or who will be issued a Medicare Supplement policy from us. If you live with another adult who is your legal spouse, we will waive the one-year requirement. We may request additional documentation to determine eligibility.

Your policy's household premium discount will be terminated if the other Medicare Supplement policyholder chooses to terminate their Medicare Supplement policy or they no longer reside with you.

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.

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.

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$0	$1632 (Part A deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 $240 (Part B deductible) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 $240 (Part B deductible) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $240 (Part B deductible) $0

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $240 (Part B deductible) Generally 20%	 $0 $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $240 of Medicare Approved amounts* Remainder of Medicare Approved amounts	 $0 $0 80%	 All costs $240 (Part B deductible) 20%	 $0 $0 $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	$0	$0
- First $240 of Medicare Approved Amounts*	$0	$240 (Part B deductible)	$0
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G
MEDICARE (PART B) – MEDICAL SERVICES-PER – CALENDAR YEAR

*Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 $240 (Unless Part B deductible has been met) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 $240 (Unless Part B deductible has been met) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment - First $240 of Medicare Approved Amounts*	$0	$0	$240 (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

HIGH DEDUCTIBLE PLAN G
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. **This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE ** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0***
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE ** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 Generally 80%	$0 Generally 20%	$240 (Unless Part B deductible has been met) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $240 of Medicare Approved amounts* Remainder of Medicare Approved amounts	$0 $0 80%	All costs $0 20%	$0 $240 (Unless Part B deductible has been met) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE ** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment - First $240 of Medicare Approved Amounts*	$0	$0	$240 (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE ** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $240 of Medicare Approved Amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare Approved Amounts*	$0	$0	$240 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment - First $240 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $240 (Part B deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.