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.

Effective 8-1-2024

ACE PROPERTY & CASUALTY INSURANCE COMPANY

Policy Fee $25

KANSAS Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 660-662, 672

	Preferred				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	1,712	2,057	1,793	686	1,310
65	1,712	2,057	1,793	686	1,310
66	1,712	2,057	1,793	686	1,310
67	1,712	2,057	1,793	686	1,310
68	1,712	2,115	1,793	686	1,316
69	1,721	2,177	1,802	688	1,333
70	1,744	2,243	1,826	698	1,359
71	1,795	2,310	1,881	718	1,399
72	1,858	2,390	1,945	743	1,448
73	1,923	2,475	2,014	770	1,498
74	1,990	2,560	2,084	796	1,551
75	2,070	2,663	2,168	828	1,613
76	2,153	2,770	2,255	862	1,677
77	2,238	2,881	2,344	896	1,745
78	2,328	2,995	2,438	932	1,814
79	2,421	3,115	2,535	969	1,887
80	2,517	3,239	2,638	1,008	1,961
81	2,630	3,385	2,755	1,053	2,051
82	2,750	3,537	2,879	1,099	2,142
83	2,873	3,696	3,010	1,150	2,239
84	3,001	3,862	3,144	1,201	2,340
85	3,137	4,035	3,286	1,255	2,446
86	3,278	4,218	3,434	1,312	2,556
87	3,425	4,407	3,588	1,371	2,671
88	3,579	4,605	3,750	1,432	2,790
89	3,740	4,813	3,918	1,497	2,916
90	3,908	5,029	4,095	1,565	3,048
91	4,085	5,256	4,278	1,635	3,184
92	4,269	5,492	4,472	1,708	3,329
93	4,461	5,740	4,672	1,785	3,478
94	4,661	5,998	4,883	1,866	3,636
95	4,872	6,268	5,103	1,950	3,799
96	5,090	6,550	5,332	2,037	3,970
97	5,319	6,846	5,571	2,129	4,149
98	5,559	7,154	5,823	2,224	4,336
99	5,809	7,475	6,085	2,325	4,531

	Standard				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	1,969	2,367	2,061	789	1,506
65	1,969	2,367	2,061	789	1,506
66	1,969	2,367	2,061	789	1,506
67	1,969	2,367	2,061	789	1,506
68	1,969	2,430	2,061	789	1,513
69	1,979	2,503	2,073	793	1,535
70	2,005	2,579	2,099	803	1,562
71	2,065	2,656	2,163	826	1,609
72	2,138	2,749	2,238	855	1,666
73	2,211	2,845	2,315	884	1,723
74	2,289	2,944	2,397	916	1,783
75	2,380	3,063	2,492	952	1,854
76	2,475	3,184	2,593	991	1,928
77	2,573	3,312	2,696	1,030	2,005
78	2,677	3,444	2,804	1,072	2,087
79	2,784	3,582	2,916	1,115	2,169
80	2,896	3,726	3,033	1,159	2,256
81	3,025	3,893	3,169	1,211	2,357
82	3,161	4,068	3,311	1,266	2,463
83	3,303	4,250	3,460	1,322	2,575
84	3,452	4,441	3,615	1,381	2,691
85	3,607	4,642	3,779	1,443	2,812
86	3,771	4,850	3,949	1,510	2,940
87	3,939	5,070	4,127	1,576	3,071
88	4,116	5,297	4,312	1,648	3,209
89	4,302	5,534	4,506	1,721	3,355
90	4,495	5,784	4,709	1,800	3,505
91	4,698	6,045	4,919	1,879	3,663
92	4,909	6,318	5,142	1,965	3,827
93	5,130	6,601	5,373	2,053	4,000
94	5,361	6,899	5,615	2,145	4,180
95	5,602	7,209	5,868	2,242	4,369
96	5,854	7,533	6,131	2,342	4,565
97	6,117	7,872	6,408	2,448	4,772
98	6,392	8,227	6,696	2,557	4,985
99	6,681	8,597	6,998	2,673	5,211

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY

KANSAS Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 660-662, 672

	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
0-64	1,666	2,002	1,745	667	1,274	0-64	1,916	2,303	2,006	768	1,465
65	1,666	2,002	1,745	667	1,274	65	1,916	2,303	2,006	768	1,465
66	1,666	2,002	1,745	667	1,274	66	1,916	2,303	2,006	768	1,465
67	1,666	2,002	1,745	667	1,274	67	1,916	2,303	2,006	768	1,465
68	1,666	2,058	1,745	667	1,281	68	1,916	2,365	2,006	768	1,473
69	1,675	2,119	1,754	670	1,298	69	1,926	2,436	2,018	771	1,494
70	1,697	2,182	1,777	679	1,322	70	1,952	2,510	2,043	781	1,521
71	1,747	2,249	1,830	699	1,361	71	2,010	2,585	2,105	804	1,566
72	1,808	2,326	1,893	724	1,409	72	2,080	2,675	2,178	833	1,621
73	1,871	2,408	1,960	749	1,458	73	2,152	2,769	2,253	861	1,677
74	1,937	2,491	2,028	775	1,510	74	2,227	2,866	2,333	891	1,735
75	2,015	2,591	2,110	806	1,570	75	2,316	2,981	2,425	927	1,805
76	2,095	2,695	2,195	839	1,632	76	2,409	3,099	2,524	965	1,877
77	2,178	2,803	2,282	872	1,698	77	2,504	3,224	2,624	1,003	1,952
78	2,266	2,915	2,373	907	1,765	78	2,606	3,352	2,729	1,043	2,031
79	2,356	3,032	2,468	943	1,836	79	2,709	3,486	2,838	1,085	2,111
80	2,450	3,152	2,568	981	1,909	80	2,818	3,626	2,952	1,128	2,195
81	2,560	3,295	2,682	1,025	1,996	81	2,944	3,789	3,084	1,179	2,294
82	2,676	3,442	2,802	1,070	2,085	82	3,077	3,959	3,223	1,232	2,397
83	2,796	3,597	2,929	1,119	2,179	83	3,215	4,136	3,367	1,287	2,506
84	2,921	3,758	3,060	1,169	2,277	84	3,360	4,322	3,519	1,344	2,619
85	3,053	3,927	3,198	1,222	2,380	85	3,510	4,517	3,678	1,404	2,736
86	3,190	4,105	3,342	1,277	2,488	86	3,670	4,720	3,843	1,469	2,861
87	3,334	4,289	3,492	1,334	2,599	87	3,833	4,934	4,016	1,534	2,988
88	3,483	4,482	3,649	1,393	2,715	88	4,006	5,155	4,197	1,604	3,123
89	3,640	4,684	3,813	1,457	2,838	89	4,187	5,386	4,385	1,675	3,265
90	3,803	4,894	3,985	1,523	2,966	90	4,374	5,630	4,583	1,752	3,411
91	3,975	5,115	4,163	1,592	3,099	91	4,572	5,883	4,788	1,829	3,565
92	4,154	5,345	4,352	1,663	3,239	92	4,777	6,149	5,004	1,912	3,724
93	4,341	5,586	4,547	1,737	3,385	93	4,992	6,424	5,229	1,998	3,893
94	4,536	5,838	4,752	1,816	3,538	94	5,217	6,714	5,464	2,087	4,068
95	4,742	6,101	4,966	1,898	3,697	95	5,452	7,016	5,711	2,182	4,252
96	4,954	6,375	5,189	1,982	3,864	96	5,697	7,331	5,967	2,280	4,443
97	5,177	6,663	5,422	2,071	4,038	97	5,953	7,661	6,236	2,382	4,644
98	5,410	6,963	5,667	2,165	4,220	98	6,221	8,006	6,517	2,489	4,852
99	5,654	7,275	5,922	2,262	4,410	99	6,502	8,367	6,810	2,602	5,071

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

Household Discount Factor 0.93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

KANSAS Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 660-662, 672

	Preferred				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	1,522	1,829	1,595	609	1,164
65	1,522	1,829	1,595	609	1,164
66	1,522	1,829	1,595	609	1,164
67	1,522	1,829	1,595	609	1,164
68	1,522	1,879	1,595	609	1,171
69	1,529	1,935	1,602	611	1,185
70	1,549	1,993	1,623	620	1,208
71	1,596	2,053	1,671	638	1,243
72	1,651	2,124	1,729	662	1,287
73	1,710	2,200	1,790	684	1,332
74	1,769	2,276	1,853	708	1,379
75	1,839	2,368	1,927	736	1,433
76	1,913	2,462	2,005	766	1,491
77	1,989	2,560	2,084	796	1,550
78	2,069	2,663	2,168	828	1,613
79	2,152	2,770	2,254	862	1,677
80	2,238	2,879	2,344	896	1,744
81	2,338	3,008	2,450	936	1,822
82	2,444	3,144	2,559	977	1,905
83	2,553	3,285	2,674	1,021	1,990
84	2,668	3,432	2,795	1,068	2,081
85	2,789	3,588	2,920	1,116	2,174
86	2,914	3,748	3,052	1,166	2,272
87	3,044	3,918	3,190	1,219	2,374
88	3,182	4,094	3,334	1,273	2,481
89	3,325	4,278	3,482	1,331	2,593
90	3,475	4,471	3,639	1,390	2,708
91	3,631	4,672	3,803	1,453	2,830
92	3,794	4,883	3,974	1,518	2,959
93	3,965	5,102	4,153	1,586	3,092
94	4,143	5,332	4,340	1,658	3,232
95	4,330	5,572	4,536	1,734	3,376
96	4,524	5,822	4,739	1,810	3,529
97	4,729	6,085	4,954	1,892	3,687
98	4,942	6,359	5,176	1,978	3,853
99	5,163	6,644	5,408	2,067	4,028

	Standard				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	1,750	2,103	1,833	701	1,338
65	1,750	2,103	1,833	701	1,338
66	1,750	2,103	1,833	701	1,338
67	1,750	2,103	1,833	701	1,338
68	1,750	2,160	1,833	701	1,346
69	1,759	2,226	1,843	704	1,364
70	1,782	2,292	1,866	713	1,389
71	1,835	2,361	1,922	735	1,430
72	1,900	2,443	1,989	760	1,479
73	1,965	2,528	2,059	786	1,531
74	2,033	2,617	2,130	814	1,585
75	2,116	2,723	2,215	847	1,648
76	2,200	2,831	2,305	881	1,715
77	2,287	2,944	2,397	916	1,783
78	2,380	3,062	2,492	952	1,854
79	2,475	3,184	2,592	990	1,928
80	2,573	3,312	2,695	1,030	2,005
81	2,689	3,460	2,817	1,077	2,096
82	2,811	3,616	2,944	1,125	2,190
83	2,936	3,778	3,075	1,175	2,288
84	3,069	3,948	3,214	1,228	2,393
85	3,207	4,126	3,359	1,283	2,500
86	3,350	4,312	3,510	1,341	2,613
87	3,502	4,506	3,668	1,401	2,730
88	3,659	4,707	3,833	1,464	2,853
89	3,823	4,920	4,005	1,530	2,981
90	3,996	5,141	4,186	1,599	3,116
91	4,176	5,374	4,374	1,671	3,256
92	4,363	5,615	4,570	1,746	3,402
93	4,561	5,868	4,776	1,824	3,555
94	4,764	6,132	4,992	1,907	3,716
95	4,980	6,408	5,216	1,993	3,883
96	5,204	6,695	5,450	2,082	4,058
97	5,437	6,998	5,695	2,176	4,241
98	5,682	7,312	5,952	2,274	4,432
99	5,938	7,642	6,219	2,376	4,632

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

Household Discount Factor 0.93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

KANSAS Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 660-662, 672

	Preferred				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	1,481	1,780	1,552	593	1,132
65	1,481	1,780	1,552	593	1,132
66	1,481	1,780	1,552	593	1,132
67	1,481	1,780	1,552	593	1,132
68	1,481	1,828	1,552	593	1,140
69	1,488	1,883	1,559	595	1,153
70	1,508	1,940	1,579	604	1,175
71	1,554	1,998	1,627	621	1,210
72	1,607	2,067	1,683	644	1,252
73	1,664	2,141	1,742	666	1,297
74	1,722	2,216	1,804	689	1,342
75	1,790	2,304	1,875	716	1,394
76	1,862	2,396	1,951	746	1,451
77	1,936	2,491	2,028	775	1,508
78	2,014	2,591	2,110	806	1,570
79	2,094	2,695	2,193	839	1,632
80	2,178	2,802	2,282	872	1,697
81	2,276	2,928	2,384	911	1,773
82	2,378	3,060	2,491	951	1,854
83	2,484	3,197	2,602	994	1,937
84	2,597	3,340	2,720	1,039	2,025
85	2,714	3,491	2,842	1,086	2,116
86	2,836	3,648	2,970	1,135	2,211
87	2,963	3,813	3,105	1,186	2,310
88	3,096	3,984	3,244	1,239	2,414
89	3,236	4,163	3,389	1,295	2,523
90	3,382	4,351	3,542	1,353	2,636
91	3,534	4,547	3,701	1,414	2,755
92	3,692	4,752	3,867	1,478	2,880
93	3,859	4,966	4,042	1,544	3,009
94	4,032	5,189	4,224	1,614	3,145
95	4,214	5,423	4,415	1,687	3,286
96	4,403	5,666	4,612	1,762	3,434
97	4,602	5,922	4,821	1,841	3,588
98	4,810	6,188	5,038	1,925	3,750
99	5,025	6,466	5,263	2,012	3,920

	Standard				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	1,703	2,047	1,784	682	1,303
65	1,703	2,047	1,784	682	1,303
66	1,703	2,047	1,784	682	1,303
67	1,703	2,047	1,784	682	1,303
68	1,703	2,103	1,784	682	1,310
69	1,712	2,166	1,793	686	1,327
70	1,734	2,231	1,816	694	1,352
71	1,786	2,298	1,870	715	1,392
72	1,849	2,378	1,936	739	1,440
73	1,912	2,461	2,004	765	1,490
74	1,979	2,547	2,073	792	1,543
75	2,059	2,650	2,156	824	1,604
76	2,141	2,755	2,243	857	1,669
77	2,226	2,866	2,333	891	1,735
78	2,316	2,980	2,425	927	1,805
79	2,409	3,099	2,523	964	1,877
80	2,504	3,224	2,623	1,003	1,952
81	2,617	3,367	2,742	1,048	2,040
82	2,735	3,519	2,865	1,095	2,131
83	2,858	3,677	2,993	1,143	2,227
84	2,986	3,842	3,128	1,195	2,329
85	3,121	4,016	3,269	1,249	2,433
86	3,261	4,196	3,416	1,305	2,543
87	3,408	4,385	3,570	1,364	2,657
88	3,561	4,581	3,730	1,425	2,777
89	3,721	4,788	3,898	1,489	2,902
90	3,889	5,004	4,074	1,556	3,033
91	4,064	5,230	4,257	1,626	3,168
92	4,246	5,464	4,448	1,699	3,310
93	4,439	5,711	4,648	1,775	3,460
94	4,636	5,967	4,858	1,856	3,617
95	4,847	6,236	5,076	1,939	3,779
96	5,064	6,516	5,304	2,026	3,950
97	5,292	6,810	5,543	2,118	4,127
98	5,530	7,116	5,793	2,214	4,313
99	5,779	7,438	6,053	2,313	4,508

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

Household Discount Factor 0.93

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.

RENEWAL CONDITIONS

You may renew this policy as long as you live by paying the premium on time. We cannot cancel or refuse to renew your policy, or place any restrictions on it, other than for non-payment or for fraudulent misstatements made by you in your application for the policy.

CANCELLATION BY INSURED

You may cancel this policy at any time by written notice delivered or mailed to us, effective upon request or on such later date as may be specified in such notice. In the event of cancellation we shall make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation. Claims will not be paid for dates of service after the date of cancellation except as provided for under the Extension of Benefits Provision.

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.

The following information is to be filled in by an agent or employee of the company who assumes responsibility for completing this outline of coverage:

The premium amount for the policy is: $ _____

The premium mode is (Circle one): Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly ☐

Name and Address of Insurance Agent or the Employee of the Company Assuming Responsibility for Completing This Outline of Coverage:

_____

_____

_____

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 Durable medical equipment	100%	$0	$0
- 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.