ACE PROPERTY & CASUALTY INSURANCE COMPANY
Outline of Medicare Supplement Coverage
Benefit Plans Offered: A, B, 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. Every company must make Plans A, B and D or G available. 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.

Effective 08-01-2023

ACE PROPERTY & CASUALTY INSURANCE COMPANY

Policy Fee $25

PENNSYLVANIA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 189-194

	Preferred					
Attained Age	Plan A	Plan B	Plan F	Plan G	HD Plan G	Plan N
0-64	1,791	1,799	2,084	1,808	717	1,370
65	1,791	1,799	2,084	1,808	717	1,370
66	1,791	1,799	2,084	1,808	717	1,370
67	1,791	1,799	2,084	1,808	717	1,370
68	1,791	1,799	2,149	1,808	717	1,370
69	1,798	1,808	2,214	1,818	720	1,376
70	1,826	1,834	2,280	1,843	732	1,397
71	1,882	1,890	2,348	1,899	753	1,440
72	1,946	1,956	2,429	1,966	779	1,491
73	2,014	2,023	2,515	2,034	806	1,543
74	2,084	2,094	2,602	2,104	833	1,596
75	2,168	2,179	2,708	2,190	868	1,660
76	2,255	2,266	2,815	2,278	902	1,725
77	2,343	2,356	2,927	2,368	938	1,795
78	2,439	2,451	3,044	2,463	976	1,866
79	2,535	2,548	3,167	2,562	1,014	1,942
80	2,636	2,651	3,293	2,664	1,055	2,017
81	2,755	2,768	3,441	2,782	1,103	2,109
82	2,879	2,892	3,595	2,907	1,150	2,204
83	3,008	3,024	3,756	3,039	1,203	2,305
84	3,143	3,159	3,925	3,175	1,257	2,408
85	3,284	3,302	4,102	3,318	1,314	2,517
86	3,432	3,448	4,287	3,466	1,374	2,631
87	3,586	3,604	4,479	3,623	1,436	2,749
88	3,747	3,767	4,681	3,786	1,499	2,871
89	3,916	3,935	4,892	3,955	1,568	3,002
90	4,093	4,114	5,113	4,134	1,639	3,137
91	4,278	4,298	5,343	4,319	1,710	3,277
92	4,470	4,493	5,583	4,515	1,788	3,426
93	4,670	4,693	5,835	4,717	1,869	3,579
94	4,881	4,906	6,098	4,930	1,953	3,742
95	5,101	5,126	6,373	5,151	2,042	3,911
96	5,329	5,357	6,659	5,383	2,133	4,085
97	5,569	5,597	6,959	5,625	2,228	4,270
98	5,821	5,850	7,272	5,879	2,329	4,463
99	6,082	6,111	7,600	6,142	2,433	4,664

	Standard					
Attained Age	Plan A	Plan B	Plan F	Plan G	HD Plan G	Plan N
0-64	2,058	2,068	2,397	2,079	826	1,574
65	2,058	2,068	2,397	2,079	826	1,574
66	2,058	2,068	2,397	2,079	826	1,574
67	2,058	2,068	2,397	2,079	826	1,574
68	2,058	2,068	2,471	2,079	826	1,574
69	2,068	2,079	2,545	2,090	828	1,584
70	2,100	2,111	2,620	2,122	841	1,607
71	2,164	2,174	2,701	2,184	865	1,656
72	2,239	2,251	2,793	2,262	896	1,713
73	2,316	2,327	2,891	2,339	926	1,775
74	2,396	2,408	2,993	2,420	959	1,835
75	2,494	2,506	3,113	2,518	999	1,909
76	2,592	2,606	3,237	2,619	1,037	1,984
77	2,695	2,710	3,365	2,723	1,079	2,062
78	2,804	2,816	3,500	2,831	1,123	2,146
79	2,916	2,931	3,641	2,946	1,168	2,231
80	3,032	3,048	3,787	3,063	1,214	2,319
81	3,167	3,184	3,957	3,200	1,268	2,426
82	3,311	3,326	4,135	3,343	1,325	2,535
83	3,460	3,476	4,320	3,494	1,383	2,651
84	3,614	3,631	4,514	3,650	1,446	2,770
85	3,778	3,796	4,719	3,815	1,511	2,894
86	3,948	3,966	4,929	3,986	1,581	3,026
87	4,123	4,145	5,151	4,166	1,651	3,161
88	4,310	4,333	5,382	4,354	1,725	3,303
89	4,505	4,527	5,625	4,550	1,802	3,453
90	4,706	4,730	5,879	4,754	1,885	3,608
91	4,918	4,941	6,144	4,966	1,968	3,770
92	5,139	5,166	6,422	5,191	2,058	3,939
93	5,371	5,398	6,711	5,425	2,149	4,117
94	5,613	5,641	7,013	5,669	2,245	4,303
95	5,866	5,895	7,329	5,925	2,348	4,497
96	6,129	6,159	7,658	6,190	2,453	4,699
97	6,403	6,437	8,001	6,469	2,564	4,912
98	6,693	6,726	8,363	6,760	2,677	5,131
99	6,994	7,029	8,740	7,064	2,800	5,364

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY

PENNSYLVANIA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 150-154, 156

	Preferred					
Attained Age	Plan A	Plan B	Plan F	Plan G	HD Plan G	Plan N
0-64	1,565	1,572	1,822	1,580	627	1,197
65	1,565	1,572	1,822	1,580	627	1,197
66	1,565	1,572	1,822	1,580	627	1,197
67	1,565	1,572	1,822	1,580	627	1,197
68	1,565	1,572	1,878	1,580	627	1,197
69	1,571	1,580	1,935	1,589	629	1,203
70	1,596	1,603	1,992	1,611	640	1,221
71	1,645	1,652	2,053	1,660	658	1,258
72	1,700	1,710	2,123	1,718	681	1,303
73	1,760	1,768	2,198	1,777	704	1,348
74	1,822	1,830	2,274	1,839	728	1,395
75	1,895	1,904	2,367	1,914	758	1,451
76	1,971	1,980	2,460	1,991	788	1,508
77	2,048	2,059	2,558	2,070	820	1,569
78	2,132	2,142	2,661	2,153	853	1,631
79	2,216	2,227	2,768	2,239	887	1,697
80	2,304	2,317	2,878	2,329	922	1,763
81	2,408	2,420	3,007	2,431	964	1,844
82	2,516	2,528	3,142	2,541	1,005	1,927
83	2,629	2,643	3,283	2,656	1,052	2,014
84	2,747	2,761	3,431	2,775	1,099	2,104
85	2,871	2,886	3,586	2,900	1,149	2,200
86	3,000	3,014	3,747	3,029	1,201	2,300
87	3,134	3,150	3,915	3,167	1,255	2,402
88	3,275	3,293	4,091	3,309	1,310	2,510
89	3,423	3,439	4,276	3,457	1,370	2,624
90	3,577	3,596	4,469	3,613	1,433	2,742
91	3,739	3,756	4,670	3,775	1,495	2,864
92	3,907	3,927	4,880	3,946	1,563	2,995
93	4,082	4,101	5,100	4,122	1,633	3,128
94	4,266	4,288	5,330	4,309	1,707	3,270
95	4,458	4,480	5,570	4,502	1,785	3,418
96	4,657	4,682	5,820	4,705	1,864	3,571
97	4,867	4,892	6,083	4,916	1,947	3,732
98	5,087	5,113	6,356	5,139	2,035	3,901
99	5,316	5,341	6,642	5,368	2,126	4,076

	Standard					
Attained Age	Plan A	Plan B	Plan F	Plan G	HD Plan G	Plan N
0-64	1,798	1,808	2,095	1,817	722	1,376
65	1,798	1,808	2,095	1,817	722	1,376
66	1,798	1,808	2,095	1,817	722	1,376
67	1,798	1,808	2,095	1,817	722	1,376
68	1,798	1,808	2,160	1,817	722	1,376
69	1,808	1,817	2,225	1,826	724	1,384
70	1,836	1,845	2,290	1,854	735	1,405
71	1,892	1,900	2,361	1,909	756	1,448
72	1,957	1,967	2,442	1,977	783	1,497
73	2,024	2,034	2,527	2,044	809	1,552
74	2,094	2,105	2,616	2,115	838	1,603
75	2,179	2,190	2,721	2,200	873	1,668
76	2,266	2,277	2,829	2,289	906	1,734
77	2,355	2,368	2,941	2,380	943	1,802
78	2,451	2,462	3,059	2,474	981	1,876
79	2,549	2,562	3,183	2,575	1,020	1,950
80	2,650	2,664	3,310	2,677	1,061	2,027
81	2,768	2,783	3,459	2,797	1,108	2,121
82	2,894	2,907	3,614	2,922	1,158	2,215
83	3,024	3,038	3,776	3,054	1,209	2,317
84	3,159	3,174	3,946	3,190	1,264	2,421
85	3,302	3,318	4,125	3,334	1,321	2,529
86	3,451	3,466	4,308	3,484	1,382	2,645
87	3,604	3,622	4,502	3,641	1,443	2,762
88	3,767	3,787	4,704	3,805	1,508	2,887
89	3,937	3,957	4,917	3,977	1,575	3,018
90	4,113	4,134	5,138	4,155	1,647	3,154
91	4,298	4,318	5,370	4,340	1,720	3,295
92	4,492	4,515	5,613	4,537	1,799	3,442
93	4,695	4,718	5,866	4,741	1,878	3,598
94	4,906	4,930	6,130	4,955	1,962	3,761
95	5,127	5,153	6,406	5,178	2,053	3,931
96	5,357	5,383	6,693	5,410	2,144	4,107
97	5,597	5,626	6,993	5,654	2,241	4,293
98	5,850	5,879	7,310	5,908	2,340	4,485
99	6,113	6,143	7,639	6,174	2,447	4,688

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

Household Discount Factor .93

Effective 08-01-2023

ACE PROPERTY & CASUALTY INSURANCE COMPANY

Policy Fee $25

PENNSYLVANIA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 150-154, 156, 189-194

	Preferred					
					HD	
Attained Age	Plan A	Plan B	Plan F	Plan G	Plan G	Plan N
0-64	1,424	1,431	1,658	1,438	570	1,089
65	1,424	1,431	1,658	1,438	570	1,089
66	1,424	1,431	1,658	1,438	570	1,089
67	1,424	1,431	1,658	1,438	570	1,089
68	1,424	1,431	1,709	1,438	570	1,089
69	1,430	1,438	1,760	1,445	572	1,095
70	1,452	1,458	1,813	1,466	582	1,111
71	1,496	1,503	1,868	1,510	599	1,145
72	1,547	1,556	1,932	1,563	620	1,186
73	1,601	1,609	2,000	1,617	641	1,227
74	1,658	1,665	2,069	1,673	663	1,269
75	1,724	1,733	2,153	1,741	690	1,320
76	1,793	1,802	2,238	1,811	717	1,372
77	1,863	1,874	2,328	1,883	746	1,427
78	1,940	1,949	2,421	1,959	776	1,484
79	2,016	2,027	2,519	2,037	807	1,544
80	2,097	2,108	2,619	2,119	839	1,604
81	2,191	2,202	2,736	2,212	877	1,677
82	2,290	2,300	2,859	2,312	915	1,753
83	2,392	2,405	2,987	2,417	957	1,833
84	2,500	2,512	3,122	2,525	1,000	1,915
85	2,612	2,626	3,263	2,639	1,045	2,002
86	2,730	2,742	3,410	2,756	1,092	2,092
87	2,852	2,867	3,562	2,881	1,142	2,186
88	2,980	2,996	3,723	3,011	1,192	2,284
89	3,115	3,130	3,891	3,145	1,247	2,388
90	3,255	3,272	4,066	3,288	1,304	2,495
91	3,402	3,418	4,249	3,435	1,360	2,606
92	3,555	3,573	4,440	3,591	1,422	2,725
93	3,714	3,732	4,641	3,751	1,486	2,847
94	3,881	3,902	4,850	3,921	1,554	2,976
95	4,056	4,077	5,068	4,097	1,624	3,110
96	4,238	4,260	5,296	4,281	1,696	3,249
97	4,429	4,451	5,535	4,473	1,772	3,396
98	4,629	4,652	5,784	4,676	1,852	3,549
99	4,837	4,860	6,044	4,885	1,935	3,709

	Standard					
					HD	
Attained Age	Plan A	Plan B	Plan F	Plan G	Plan G	Plan N
0-64	1,636	1,645	1,906	1,653	657	1,252
65	1,636	1,645	1,906	1,653	657	1,252
66	1,636	1,645	1,906	1,653	657	1,252
67	1,636	1,645	1,906	1,653	657	1,252
68	1,636	1,645	1,965	1,653	657	1,252
69	1,645	1,653	2,024	1,662	659	1,259
70	1,670	1,679	2,084	1,687	669	1,278
71	1,721	1,729	2,148	1,737	688	1,317
72	1,781	1,790	2,222	1,799	712	1,362
73	1,842	1,851	2,299	1,860	736	1,412
74	1,906	1,915	2,380	1,925	763	1,459
75	1,983	1,993	2,476	2,002	794	1,518
76	2,062	2,072	2,575	2,083	825	1,578
77	2,143	2,155	2,676	2,166	858	1,640
78	2,230	2,240	2,784	2,251	893	1,707
79	2,319	2,331	2,896	2,343	929	1,774
80	2,412	2,424	3,011	2,436	965	1,845
81	2,519	2,532	3,147	2,545	1,008	1,930
82	2,633	2,645	3,289	2,659	1,054	2,016
83	2,752	2,765	3,436	2,779	1,100	2,108
84	2,874	2,888	3,590	2,903	1,150	2,203
85	3,004	3,019	3,753	3,034	1,202	2,301
86	3,140	3,154	3,920	3,170	1,257	2,406
87	3,279	3,296	4,097	3,313	1,313	2,514
88	3,428	3,446	4,280	3,463	1,372	2,627
89	3,582	3,600	4,474	3,618	1,433	2,746
90	3,743	3,762	4,675	3,781	1,499	2,870
91	3,911	3,929	4,886	3,949	1,565	2,998
92	4,087	4,108	5,107	4,129	1,637	3,132
93	4,272	4,293	5,337	4,314	1,709	3,274
94	4,464	4,486	5,578	4,508	1,786	3,422
95	4,665	4,688	5,829	4,712	1,868	3,577
96	4,874	4,898	6,090	4,923	1,951	3,737
97	5,093	5,119	6,363	5,144	2,039	3,906
98	5,323	5,349	6,651	5,376	2,129	4,081
99	5,562	5,590	6,950	5,617	2,227	4,266

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY

PENNSYLVANIA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 189-194

	Preferred					
					HD	
Attained Age	Plan A	Plan B	Plan F	Plan G	Plan G	Plan N
0-64	1,591	1,600	1,853	1,608	638	1,218
65	1,591	1,600	1,853	1,608	638	1,218
66	1,591	1,600	1,853	1,608	638	1,218
67	1,591	1,600	1,853	1,608	638	1,218
68	1,591	1,600	1,910	1,608	638	1,218
69	1,599	1,607	1,967	1,615	639	1,223
70	1,623	1,631	2,026	1,639	650	1,243
71	1,672	1,680	2,087	1,688	668	1,280
72	1,730	1,739	2,160	1,748	692	1,325
73	1,791	1,799	2,235	1,808	716	1,371
74	1,852	1,862	2,313	1,871	741	1,419
75	1,927	1,936	2,406	1,946	771	1,475
76	2,004	2,014	2,502	2,024	802	1,533
77	2,083	2,094	2,602	2,104	833	1,594
78	2,168	2,179	2,706	2,190	868	1,659
79	2,254	2,264	2,815	2,276	902	1,725
80	2,343	2,355	2,927	2,367	938	1,794
81	2,448	2,462	3,058	2,474	980	1,874
82	2,559	2,571	3,196	2,584	1,024	1,960
83	2,674	2,687	3,339	2,700	1,070	2,049
84	2,794	2,807	3,490	2,822	1,117	2,141
85	2,920	2,934	3,647	2,948	1,169	2,237
86	3,051	3,066	3,811	3,082	1,220	2,338
87	3,187	3,204	3,982	3,220	1,276	2,443
88	3,331	3,348	4,161	3,366	1,334	2,553
89	3,482	3,499	4,348	3,516	1,393	2,668
90	3,638	3,655	4,545	3,674	1,456	2,788
91	3,802	3,820	4,750	3,839	1,522	2,914
92	3,972	3,992	4,964	4,013	1,590	3,044
93	4,151	4,171	5,187	4,193	1,662	3,182
94	4,338	4,361	5,421	4,382	1,736	3,326
95	4,534	4,557	5,664	4,579	1,815	3,475
96	4,737	4,761	5,919	4,785	1,895	3,632
97	4,950	4,975	6,185	5,001	1,981	3,796
98	5,174	5,198	6,464	5,225	2,070	3,966
99	5,406	5,433	6,755	5,459	2,163	4,146

	Standard					
					HD	
Attained Age	Plan A	Plan B	Plan F	Plan G	Plan G	Plan N
0-64	1,830	1,839	2,130	1,848	733	1,400
65	1,830	1,839	2,130	1,848	733	1,400
66	1,830	1,839	2,130	1,848	733	1,400
67	1,830	1,839	2,130	1,848	733	1,400
68	1,830	1,839	2,196	1,848	733	1,400
69	1,839	1,848	2,263	1,858	736	1,407
70	1,866	1,876	2,330	1,886	748	1,429
71	1,923	1,932	2,401	1,942	769	1,473
72	1,990	1,999	2,483	2,010	796	1,523
73	2,059	2,068	2,569	2,079	824	1,577
74	2,130	2,140	2,661	2,151	852	1,631
75	2,216	2,227	2,767	2,238	888	1,696
76	2,304	2,316	2,877	2,328	922	1,763
77	2,396	2,408	2,992	2,420	959	1,833
78	2,494	2,506	3,112	2,518	997	1,907
79	2,592	2,604	3,237	2,618	1,037	1,984
80	2,695	2,708	3,365	2,722	1,079	2,062
81	2,815	2,830	3,517	2,844	1,128	2,156
82	2,943	2,956	3,676	2,971	1,177	2,253
83	3,075	3,090	3,841	3,106	1,230	2,356
84	3,212	3,228	4,013	3,244	1,285	2,462
85	3,358	3,374	4,195	3,391	1,343	2,573
86	3,508	3,526	4,382	3,543	1,405	2,689
87	3,666	3,684	4,579	3,703	1,467	2,809
88	3,831	3,850	4,784	3,870	1,533	2,936
89	4,003	4,025	5,001	4,045	1,602	3,068
90	4,183	4,205	5,225	4,226	1,675	3,207
91	4,373	4,393	5,462	4,415	1,750	3,351
92	4,567	4,591	5,707	4,614	1,828	3,500
93	4,775	4,798	5,965	4,822	1,910	3,660
94	4,989	5,014	6,234	5,039	1,996	3,824
95	5,214	5,239	6,514	5,266	2,087	3,997
96	5,447	5,475	6,806	5,503	2,181	4,176
97	5,691	5,721	7,113	5,750	2,278	4,365
98	5,950	5,978	7,433	6,009	2,380	4,562
99	6,217	6,246	7,769	6,278	2,488	4,768

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY

PENNSYLVANIA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 150-154, 156

	Preferred					
Attained Age	Plan A	Plan B	Plan F	Plan G	HD Plan G	Plan N
0-64	1,390	1,399	1,620	1,406	558	1,064
65	1,390	1,399	1,620	1,406	558	1,064
66	1,390	1,399	1,620	1,406	558	1,064
67	1,390	1,399	1,620	1,406	558	1,064
68	1,390	1,399	1,669	1,406	558	1,064
69	1,397	1,404	1,719	1,411	559	1,069
70	1,418	1,425	1,771	1,432	568	1,086
71	1,462	1,469	1,824	1,476	584	1,119
72	1,512	1,520	1,887	1,528	605	1,158
73	1,565	1,572	1,953	1,580	626	1,198
74	1,619	1,627	2,021	1,635	648	1,240
75	1,684	1,692	2,103	1,700	674	1,289
76	1,752	1,760	2,186	1,769	701	1,340
77	1,821	1,830	2,274	1,839	728	1,393
78	1,895	1,904	2,365	1,914	758	1,450
79	1,970	1,979	2,460	1,990	788	1,508
80	2,048	2,058	2,558	2,069	820	1,568
81	2,140	2,152	2,672	2,162	857	1,638
82	2,237	2,247	2,794	2,259	895	1,713
83	2,337	2,348	2,918	2,360	935	1,790
84	2,442	2,453	3,050	2,466	977	1,871
85	2,552	2,564	3,187	2,577	1,022	1,956
86	2,667	2,679	3,330	2,693	1,067	2,043
87	2,786	2,801	3,481	2,815	1,115	2,136
88	2,911	2,927	3,636	2,942	1,166	2,231
89	3,043	3,058	3,800	3,073	1,218	2,332
90	3,179	3,195	3,972	3,211	1,272	2,437
91	3,323	3,339	4,151	3,355	1,330	2,547
92	3,472	3,490	4,338	3,507	1,390	2,661
93	3,628	3,646	4,533	3,664	1,452	2,781
94	3,791	3,811	4,738	3,830	1,517	2,907
95	3,963	3,983	4,950	4,002	1,586	3,037
96	4,140	4,161	5,173	4,182	1,657	3,175
97	4,326	4,348	5,406	4,371	1,732	3,318
98	4,522	4,543	5,650	4,566	1,809	3,467
99	4,725	4,748	5,904	4,772	1,891	3,624

	Standard					
Attained Age	Plan A	Plan B	Plan F	Plan G	HD Plan G	Plan N
0-64	1,599	1,607	1,862	1,615	641	1,224
65	1,599	1,607	1,862	1,615	641	1,224
66	1,599	1,607	1,862	1,615	641	1,224
67	1,599	1,607	1,862	1,615	641	1,224
68	1,599	1,607	1,920	1,615	641	1,224
69	1,607	1,615	1,977	1,624	643	1,229
70	1,631	1,640	2,036	1,648	653	1,249
71	1,681	1,689	2,099	1,697	672	1,287
72	1,739	1,747	2,170	1,756	696	1,331
73	1,800	1,808	2,245	1,817	720	1,378
74	1,861	1,871	2,326	1,880	745	1,426
75	1,937	1,946	2,418	1,956	776	1,482
76	2,014	2,024	2,514	2,035	806	1,541
77	2,094	2,105	2,615	2,115	838	1,602
78	2,179	2,190	2,720	2,200	872	1,667
79	2,266	2,276	2,829	2,288	906	1,734
80	2,355	2,367	2,941	2,379	943	1,802
81	2,460	2,473	3,074	2,486	986	1,884
82	2,572	2,584	3,213	2,597	1,029	1,969
83	2,688	2,700	3,357	2,714	1,075	2,059
84	2,808	2,822	3,507	2,836	1,123	2,152
85	2,935	2,949	3,666	2,964	1,174	2,249
86	3,066	3,082	3,830	3,097	1,228	2,350
87	3,204	3,220	4,002	3,237	1,283	2,455
88	3,348	3,365	4,181	3,382	1,340	2,566
89	3,499	3,517	4,371	3,535	1,400	2,682
90	3,656	3,675	4,567	3,693	1,464	2,803
91	3,822	3,839	4,773	3,859	1,530	2,929
92	3,992	4,013	4,988	4,033	1,598	3,059
93	4,174	4,193	5,213	4,214	1,669	3,199
94	4,360	4,382	5,449	4,404	1,744	3,342
95	4,557	4,579	5,694	4,603	1,824	3,493
96	4,761	4,786	5,949	4,810	1,906	3,650
97	4,974	5,000	6,216	5,026	1,991	3,815
98	5,200	5,225	6,497	5,252	2,080	3,987
99	5,434	5,459	6,790	5,487	2,175	4,167

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY

PENNSYLVANIA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 150-154, 156, 189-194

	Preferred					
					HD	
Attained Age	Plan A	Plan B	Plan F	Plan G	Plan G	Plan N
0-64	1,265	1,273	1,474	1,279	507	968
65	1,265	1,273	1,474	1,279	507	968
66	1,265	1,273	1,474	1,279	507	968
67	1,265	1,273	1,474	1,279	507	968
68	1,265	1,273	1,519	1,279	507	968
69	1,272	1,278	1,564	1,284	508	973
70	1,291	1,297	1,611	1,303	517	988
71	1,330	1,336	1,660	1,343	532	1,018
72	1,375	1,383	1,717	1,390	550	1,054
73	1,424	1,431	1,777	1,438	569	1,090
74	1,473	1,480	1,839	1,488	589	1,128
75	1,532	1,540	1,914	1,547	613	1,173
76	1,594	1,601	1,989	1,610	638	1,220
77	1,657	1,665	2,069	1,673	663	1,268
78	1,724	1,733	2,152	1,741	690	1,319
79	1,792	1,801	2,238	1,810	717	1,372
80	1,863	1,873	2,328	1,882	746	1,426
81	1,947	1,958	2,432	1,967	779	1,491
82	2,035	2,045	2,542	2,055	814	1,559
83	2,126	2,137	2,655	2,148	851	1,629
84	2,222	2,232	2,775	2,244	889	1,703
85	2,322	2,333	2,900	2,345	930	1,779
86	2,426	2,438	3,030	2,451	971	1,859
87	2,535	2,548	3,167	2,561	1,015	1,943
88	2,649	2,663	3,309	2,677	1,061	2,030
89	2,769	2,783	3,458	2,797	1,108	2,122
90	2,893	2,907	3,614	2,922	1,158	2,217
91	3,023	3,038	3,777	3,053	1,210	2,317
92	3,159	3,175	3,947	3,191	1,265	2,421
93	3,301	3,317	4,125	3,334	1,321	2,530
94	3,450	3,468	4,311	3,485	1,380	2,645
95	3,606	3,624	4,504	3,642	1,443	2,764
96	3,767	3,786	4,707	3,805	1,507	2,889
97	3,937	3,957	4,919	3,977	1,576	3,019
98	4,115	4,134	5,141	4,155	1,646	3,154
99	4,299	4,320	5,372	4,342	1,721	3,297

	Standard					
					HD	
Attained Age	Plan A	Plan B	Plan F	Plan G	Plan G	Plan N
0-64	1,455	1,462	1,694	1,470	583	1,113
65	1,455	1,462	1,694	1,470	583	1,113
66	1,455	1,462	1,694	1,470	583	1,113
67	1,455	1,462	1,694	1,470	583	1,113
68	1,455	1,462	1,747	1,470	583	1,113
69	1,462	1,470	1,799	1,477	585	1,119
70	1,484	1,492	1,853	1,500	595	1,137
71	1,529	1,537	1,910	1,544	611	1,171
72	1,582	1,590	1,975	1,598	633	1,211
73	1,637	1,645	2,043	1,653	655	1,254
74	1,694	1,702	2,117	1,711	678	1,297
75	1,763	1,771	2,201	1,780	706	1,349
76	1,833	1,842	2,288	1,852	733	1,402
77	1,906	1,915	2,379	1,925	763	1,458
78	1,983	1,993	2,475	2,002	793	1,517
79	2,062	2,071	2,575	2,082	825	1,578
80	2,143	2,154	2,676	2,164	858	1,640
81	2,239	2,250	2,797	2,262	897	1,714
82	2,341	2,351	2,923	2,363	936	1,792
83	2,446	2,457	3,055	2,470	978	1,874
84	2,555	2,567	3,191	2,580	1,022	1,958
85	2,670	2,683	3,336	2,697	1,068	2,046
86	2,790	2,804	3,485	2,818	1,118	2,139
87	2,915	2,930	3,642	2,945	1,167	2,234
88	3,047	3,062	3,805	3,078	1,220	2,335
89	3,184	3,201	3,977	3,216	1,274	2,440
90	3,327	3,344	4,155	3,361	1,332	2,550
91	3,477	3,493	4,343	3,511	1,392	2,665
92	3,632	3,651	4,539	3,669	1,454	2,784
93	3,798	3,816	4,744	3,835	1,519	2,911
94	3,967	3,987	4,958	4,008	1,587	3,041
95	4,147	4,167	5,181	4,188	1,660	3,179
96	4,332	4,354	5,413	4,377	1,734	3,321
97	4,526	4,550	5,656	4,573	1,812	3,472
98	4,732	4,754	5,912	4,779	1,893	3,628
99	4,944	4,967	6,178	4,993	1,979	3,792

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. NOTE: The policy fee is fully refundable if the policy is not issued, delivery of the policy is refused or the policy is returned with the policy's 30-day free look period.

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 B

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	$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 B

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 (Part B deductible) $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 (Part B deductible) $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 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	$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 for the high deductible Plan G will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid directly by the policy. This includes the Medicare deductible for Part A, but 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 for the high deductible Plan G will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid directly by the policy. This includes the Medicare deductible for Part A, but 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 (Part B deductible) $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 (Part B deductible) $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 (Part B deductible)
- 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.