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

IOWA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 515

	Preferred					Standard					
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,437	1,762	1,505	575	1,110	65	1,652	2,026	1,730	662	1,276
66	1,437	1,762	1,505	575	1,110	66	1,652	2,026	1,730	662	1,276
67	1,437	1,762	1,505	575	1,110	67	1,652	2,026	1,730	662	1,276
68	1,437	1,810	1,505	575	1,115	68	1,652	2,080	1,730	662	1,283
69	1,444	1,864	1,512	578	1,131	69	1,661	2,143	1,740	665	1,301
70	1,464	1,919	1,532	586	1,152	70	1,683	2,208	1,762	674	1,324
71	1,506	1,977	1,579	603	1,186	71	1,733	2,274	1,815	694	1,364
72	1,559	2,046	1,633	624	1,228	72	1,794	2,353	1,878	718	1,412
73	1,614	2,119	1,690	646	1,270	73	1,856	2,436	1,943	742	1,461
74	1,670	2,191	1,749	668	1,314	74	1,921	2,520	2,012	769	1,511
75	1,738	2,280	1,820	695	1,367	75	1,998	2,622	2,091	799	1,572
76	1,807	2,370	1,893	723	1,421	76	2,078	2,726	2,177	832	1,634
77	1,878	2,466	1,968	752	1,479	77	2,160	2,836	2,263	865	1,700
78	1,954	2,564	2,046	782	1,537	78	2,247	2,949	2,353	900	1,770
79	2,032	2,667	2,128	813	1,600	79	2,337	3,067	2,447	935	1,838
80	2,113	2,773	2,214	846	1,663	80	2,430	3,189	2,546	972	1,912
81	2,208	2,898	2,313	884	1,738	81	2,539	3,333	2,660	1,017	1,999
82	2,308	3,027	2,416	923	1,816	82	2,653	3,482	2,779	1,062	2,088
83	2,411	3,164	2,526	965	1,898	83	2,773	3,638	2,904	1,110	2,182
84	2,519	3,306	2,639	1,008	1,984	84	2,897	3,802	3,034	1,159	2,281
85	2,633	3,454	2,758	1,054	2,073	85	3,027	3,973	3,172	1,211	2,383
86	2,751	3,611	2,882	1,101	2,167	86	3,165	4,152	3,314	1,267	2,492
87	2,875	3,773	3,011	1,151	2,264	87	3,306	4,340	3,463	1,323	2,603
88	3,004	3,943	3,147	1,202	2,365	88	3,455	4,534	3,619	1,383	2,721
89	3,139	4,120	3,289	1,256	2,472	89	3,610	4,738	3,782	1,444	2,844
90	3,280	4,305	3,437	1,313	2,584	90	3,772	4,952	3,952	1,511	2,971
91	3,428	4,500	3,590	1,373	2,699	91	3,943	5,176	4,129	1,577	3,105
92	3,583	4,702	3,753	1,434	2,821	92	4,120	5,409	4,316	1,649	3,243
93	3,744	4,914	3,921	1,498	2,949	93	4,305	5,651	4,509	1,723	3,391
94	3,912	5,135	4,098	1,566	3,082	94	4,499	5,906	4,712	1,800	3,543
95	4,089	5,366	4,282	1,637	3,220	95	4,702	6,172	4,925	1,881	3,704
96	4,272	5,607	4,475	1,709	3,366	96	4,913	6,448	5,146	1,966	3,870
97	4,464	5,861	4,676	1,786	3,517	97	5,134	6,739	5,378	2,055	4,045
98	4,666	6,125	4,887	1,867	3,675	98	5,365	7,042	5,620	2,146	4,226
99	4,876	6,400	5,107	1,951	3,841	99	5,607	7,360	5,873	2,244	4,416

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY

IOWA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 515

	Preferred						Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,360	1,668	1,424	545	1,051	65	1,564	1,918	1,638	627	1,209
66	1,360	1,668	1,424	545	1,051	66	1,564	1,918	1,638	627	1,209
67	1,360	1,668	1,424	545	1,051	67	1,564	1,918	1,638	627	1,209
68	1,360	1,714	1,424	545	1,056	68	1,564	1,970	1,638	627	1,215
69	1,368	1,764	1,432	547	1,071	69	1,572	2,029	1,647	630	1,232
70	1,386	1,817	1,451	555	1,091	70	1,594	2,091	1,668	638	1,254
71	1,426	1,872	1,495	571	1,123	71	1,641	2,153	1,719	657	1,292
72	1,477	1,938	1,546	591	1,163	72	1,699	2,228	1,778	680	1,337
73	1,528	2,006	1,600	612	1,203	73	1,757	2,307	1,840	703	1,384
74	1,582	2,074	1,656	633	1,245	74	1,819	2,386	1,905	728	1,430
75	1,645	2,158	1,723	658	1,295	75	1,891	2,483	1,980	757	1,488
76	1,711	2,244	1,792	685	1,346	76	1,967	2,581	2,061	788	1,547
77	1,778	2,335	1,863	712	1,401	77	2,045	2,685	2,142	819	1,609
78	1,850	2,428	1,937	741	1,455	78	2,128	2,792	2,228	852	1,675
79	1,924	2,525	2,015	770	1,514	79	2,212	2,904	2,317	886	1,740
80	2,000	2,626	2,096	801	1,574	80	2,301	3,020	2,410	921	1,810
81	2,090	2,744	2,190	837	1,645	81	2,404	3,156	2,518	963	1,892
82	2,185	2,866	2,288	874	1,719	82	2,512	3,297	2,631	1,006	1,977
83	2,283	2,996	2,392	914	1,797	83	2,625	3,445	2,750	1,051	2,066
84	2,385	3,130	2,498	955	1,878	84	2,743	3,599	2,873	1,098	2,159
85	2,493	3,271	2,611	998	1,962	85	2,866	3,762	3,003	1,147	2,256
86	2,605	3,419	2,729	1,043	2,051	86	2,996	3,931	3,138	1,200	2,359
87	2,722	3,572	2,851	1,090	2,143	87	3,130	4,109	3,279	1,253	2,464
88	2,844	3,733	2,980	1,138	2,239	88	3,271	4,293	3,427	1,310	2,576
89	2,972	3,901	3,114	1,190	2,340	89	3,418	4,486	3,581	1,368	2,693
90	3,105	4,076	3,254	1,244	2,446	90	3,572	4,689	3,742	1,430	2,813
91	3,246	4,261	3,399	1,300	2,555	91	3,733	4,900	3,909	1,493	2,940
92	3,392	4,451	3,553	1,358	2,671	92	3,901	5,121	4,086	1,561	3,071
93	3,545	4,653	3,712	1,418	2,792	93	4,076	5,350	4,269	1,631	3,211
94	3,704	4,862	3,880	1,482	2,918	94	4,260	5,592	4,462	1,704	3,355
95	3,872	5,081	4,055	1,549	3,049	95	4,452	5,844	4,663	1,781	3,507
96	4,045	5,309	4,237	1,618	3,187	96	4,652	6,105	4,872	1,861	3,664
97	4,227	5,549	4,427	1,691	3,330	97	4,861	6,381	5,092	1,945	3,830
98	4,418	5,799	4,627	1,767	3,480	98	5,080	6,668	5,321	2,032	4,002
99	4,616	6,059	4,835	1,847	3,637	99	5,309	6,969	5,561	2,124	4,182

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

Household Discount Factor 0.93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

IOWA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 515

	Preferred				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
65	1,277	1,566	1,339	511	986
66	1,277	1,566	1,339	511	986
67	1,277	1,566	1,339	511	986
68	1,277	1,608	1,339	511	992
69	1,283	1,657	1,344	513	1,004
70	1,300	1,707	1,362	521	1,024
71	1,340	1,757	1,403	535	1,054
72	1,386	1,819	1,451	555	1,091
73	1,435	1,883	1,502	574	1,130
74	1,485	1,949	1,555	594	1,169
75	1,544	2,027	1,617	618	1,214
76	1,605	2,108	1,682	643	1,264
77	1,669	2,191	1,749	668	1,313
78	1,736	2,280	1,820	695	1,367
79	1,806	2,370	1,891	723	1,421
80	1,878	2,465	1,968	752	1,478
81	1,962	2,575	2,056	786	1,544
82	2,051	2,691	2,148	820	1,614
83	2,143	2,812	2,244	857	1,687
84	2,240	2,939	2,346	896	1,764
85	2,341	3,071	2,451	937	1,842
86	2,445	3,208	2,561	979	1,926
87	2,555	3,354	2,677	1,023	2,012
88	2,670	3,505	2,798	1,068	2,103
89	2,791	3,662	2,923	1,117	2,198
90	2,916	3,828	3,054	1,167	2,296
91	3,048	4,000	3,191	1,219	2,400
92	3,184	4,180	3,335	1,274	2,509
93	3,328	4,368	3,485	1,331	2,622
94	3,477	4,565	3,642	1,392	2,740
95	3,634	4,769	3,807	1,455	2,862
96	3,797	4,984	3,977	1,519	2,991
97	3,969	5,208	4,158	1,588	3,125
98	4,148	5,443	4,344	1,660	3,267
99	4,333	5,688	4,539	1,735	3,414

	Standard				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
65	1,469	1,800	1,539	588	1,135
66	1,469	1,800	1,539	588	1,135
67	1,469	1,800	1,539	588	1,135
68	1,469	1,849	1,539	588	1,141
69	1,476	1,905	1,547	591	1,156
70	1,496	1,962	1,566	599	1,177
71	1,540	2,021	1,613	617	1,212
72	1,595	2,091	1,669	638	1,254
73	1,649	2,165	1,728	660	1,298
74	1,707	2,240	1,787	683	1,344
75	1,776	2,331	1,859	711	1,397
76	1,846	2,423	1,935	739	1,454
77	1,920	2,520	2,012	769	1,511
78	1,998	2,621	2,091	799	1,572
79	2,078	2,726	2,176	831	1,634
80	2,160	2,836	2,262	865	1,700
81	2,257	2,962	2,365	904	1,777
82	2,359	3,095	2,471	944	1,856
83	2,465	3,234	2,581	986	1,940
84	2,575	3,380	2,697	1,030	2,028
85	2,692	3,532	2,819	1,077	2,119
86	2,812	3,691	2,946	1,125	2,215
87	2,939	3,857	3,079	1,176	2,314
88	3,071	4,029	3,217	1,229	2,419
89	3,209	4,211	3,362	1,284	2,528
90	3,354	4,402	3,513	1,342	2,642
91	3,505	4,600	3,671	1,402	2,760
92	3,662	4,807	3,836	1,465	2,883
93	3,828	5,023	4,008	1,531	3,013
94	3,998	5,249	4,190	1,601	3,151
95	4,180	5,486	4,378	1,672	3,292
96	4,367	5,732	4,574	1,747	3,440
97	4,563	5,990	4,780	1,827	3,595
98	4,769	6,260	4,995	1,909	3,757
99	4,983	6,542	5,220	1,994	3,927

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

Household Discount Factor 0.93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

IOWA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 515

	Preferred						Standard					
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,209	1,482	1,267	484	934	65	1,391	1,704	1,457	557	1,075
66	1,209	1,482	1,267	484	934	66	1,391	1,704	1,457	557	1,075
67	1,209	1,482	1,267	484	934	67	1,391	1,704	1,457	557	1,075
68	1,209	1,523	1,267	484	940	68	1,391	1,751	1,457	557	1,081
69	1,215	1,568	1,273	486	951	69	1,398	1,804	1,464	560	1,095
70	1,231	1,616	1,289	493	970	70	1,416	1,858	1,483	567	1,115
71	1,269	1,664	1,328	507	998	71	1,458	1,914	1,527	584	1,148
72	1,312	1,722	1,374	526	1,033	72	1,510	1,980	1,580	604	1,188
73	1,358	1,783	1,422	544	1,070	73	1,561	2,050	1,636	625	1,229
74	1,406	1,845	1,473	563	1,107	74	1,616	2,121	1,692	647	1,273
75	1,461	1,919	1,531	585	1,150	75	1,681	2,207	1,760	673	1,323
76	1,520	1,996	1,593	609	1,197	76	1,748	2,294	1,832	700	1,377
77	1,580	2,074	1,656	633	1,244	77	1,818	2,386	1,905	728	1,430
78	1,644	2,158	1,723	658	1,295	78	1,891	2,482	1,980	757	1,488
79	1,710	2,244	1,791	685	1,346	79	1,967	2,581	2,060	787	1,547
80	1,778	2,334	1,863	712	1,400	80	2,045	2,685	2,141	819	1,609
81	1,858	2,438	1,947	744	1,461	81	2,137	2,804	2,239	856	1,682
82	1,942	2,548	2,034	777	1,528	82	2,233	2,931	2,339	894	1,757
83	2,029	2,662	2,125	812	1,597	83	2,333	3,062	2,444	934	1,836
84	2,120	2,782	2,221	849	1,670	84	2,438	3,200	2,554	976	1,920
85	2,216	2,908	2,320	887	1,744	85	2,548	3,344	2,669	1,020	2,006
86	2,315	3,037	2,425	927	1,823	86	2,662	3,495	2,789	1,066	2,097
87	2,419	3,175	2,535	969	1,905	87	2,783	3,652	2,915	1,114	2,191
88	2,528	3,318	2,649	1,012	1,991	88	2,908	3,815	3,046	1,164	2,290
89	2,642	3,468	2,767	1,058	2,081	89	3,038	3,987	3,183	1,216	2,393
90	2,761	3,624	2,892	1,105	2,174	90	3,175	4,167	3,326	1,271	2,501
91	2,885	3,787	3,022	1,155	2,272	91	3,318	4,355	3,476	1,328	2,613
92	3,015	3,958	3,158	1,207	2,375	92	3,467	4,551	3,632	1,388	2,730
93	3,151	4,135	3,300	1,261	2,482	93	3,624	4,756	3,795	1,449	2,853
94	3,292	4,322	3,449	1,318	2,594	94	3,786	4,970	3,967	1,515	2,983
95	3,441	4,516	3,605	1,378	2,710	95	3,957	5,194	4,145	1,583	3,117
96	3,595	4,719	3,766	1,438	2,832	96	4,135	5,427	4,331	1,654	3,257
97	3,757	4,931	3,936	1,503	2,959	97	4,321	5,672	4,526	1,729	3,404
98	3,927	5,153	4,113	1,571	3,093	98	4,515	5,927	4,730	1,807	3,557
99	4,103	5,386	4,298	1,642	3,233	99	4,718	6,194	4,942	1,888	3,718

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.

NOTICE

This policy may not fully cover all of your medical costs. Neither ACE Property & Casualty Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. ACE Property & Casualty Insurance Company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded. Please refer to your policy for details.

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1676	$0	$1676 (Part A deductible)
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	$0	Up to $209.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN A

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

*Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 $257 (Part B deductible) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 $257 (Part B deductible) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $257 (Part B deductible) $0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1676	$1676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN F

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

*Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $257 (Part B deductible) Generally 20%	 $0 $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $257 of Medicare Approved amounts* Remainder of Medicare Approved amounts	 $0 $0 80%	 All costs $257 (Part B deductible) 20%	 $0 $0 $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies 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.