ACE PROPERTY & CASUALTY INSURANCE COMPANY
Outline of Medicare Supplement Coverage
Benefit Plans A, F, G, N and High Deductible Plan G

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available in your state. Only applicants' **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants									Medicare first eligible before 2020 only		
	A	B	D	G	G[1]	K	L	M	N	C	F	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Medicare Part B coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓ copays apply[3]	✓	✓	
Blood (first three pints)	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Part A hospice care coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Skilled nursing facility coinsurance			✓	✓		50%	75%	✓	✓	✓	✓	
Medicare Part A deductible		✓	✓	✓		50%	75%	50%	✓	✓	✓	
Medicare Part B deductible										✓	✓	
Medicare Part B excess charges				✓							✓	
Foreign travel emergency (up to plan limits)			✓	✓				✓	✓	✓	✓	
Out-of-pocket limit in 2024[2]						$7060[2]	$3530[2]					

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

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

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY

SOUTH CAROLINA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 294, 295, 298, 299

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
65	1,354	1,592	1,368	543	1,061
66	1,354	1,592	1,368	543	1,061
67	1,354	1,592	1,368	543	1,061
68	1,354	1,641	1,368	543	1,070
69	1,360	1,690	1,374	544	1,092
70	1,374	1,741	1,388	549	1,114
71	1,416	1,793	1,430	567	1,148
72	1,465	1,856	1,480	587	1,188
73	1,517	1,920	1,531	606	1,229
74	1,569	1,987	1,586	629	1,272
75	1,633	2,067	1,648	653	1,323
76	1,697	2,151	1,714	680	1,376
77	1,766	2,236	1,784	706	1,431
78	1,837	2,325	1,854	734	1,489
79	1,909	2,418	1,928	763	1,548
80	1,984	2,515	2,006	794	1,609
81	2,074	2,627	2,095	831	1,682
82	2,169	2,746	2,190	868	1,758
83	2,267	2,868	2,290	907	1,837
84	2,368	2,997	2,392	947	1,919
85	2,474	3,132	2,499	990	2,006
86	2,586	3,274	2,612	1,034	2,095
87	2,702	3,421	2,729	1,081	2,191
88	2,823	3,575	2,851	1,129	2,289
89	2,950	3,736	2,980	1,180	2,392
90	3,083	3,904	3,115	1,233	2,500
91	3,222	4,081	3,255	1,290	2,612
92	3,366	4,263	3,401	1,347	2,730
93	3,519	4,456	3,555	1,409	2,855
94	3,677	4,655	3,715	1,472	2,983
95	3,843	4,866	3,882	1,537	3,116
96	4,016	5,085	4,056	1,607	3,256
97	4,197	5,314	4,239	1,680	3,403
98	4,387	5,553	4,430	1,755	3,557
99	4,584	5,802	4,629	1,835	3,717

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
65	1,556	1,832	1,572	624	1,219
66	1,556	1,832	1,572	624	1,219
67	1,556	1,832	1,572	624	1,219
68	1,556	1,887	1,572	624	1,231
69	1,564	1,943	1,581	627	1,256
70	1,581	2,002	1,597	633	1,282
71	1,629	2,061	1,645	652	1,319
72	1,686	2,134	1,702	675	1,367
73	1,744	2,209	1,762	698	1,413
74	1,804	2,286	1,823	724	1,462
75	1,878	2,378	1,895	750	1,522
76	1,951	2,473	1,973	781	1,583
77	2,029	2,571	2,051	813	1,646
78	2,112	2,673	2,131	845	1,712
79	2,196	2,780	2,217	878	1,780
80	2,282	2,892	2,307	913	1,852
81	2,385	3,022	2,410	955	1,933
82	2,493	3,156	2,518	997	2,021
83	2,606	3,299	2,633	1,044	2,111
84	2,724	3,447	2,749	1,090	2,208
85	2,845	3,603	2,874	1,139	2,305
86	2,974	3,765	3,004	1,190	2,410
87	3,108	3,936	3,137	1,244	2,519
88	3,245	4,111	3,278	1,299	2,633
89	3,393	4,296	3,427	1,358	2,753
90	3,546	4,491	3,581	1,419	2,875
91	3,705	4,692	3,744	1,483	3,005
92	3,871	4,904	3,910	1,549	3,140
93	4,047	5,124	4,087	1,620	3,283
94	4,228	5,355	4,270	1,693	3,430
95	4,420	5,595	4,464	1,768	3,584
96	4,618	5,846	4,664	1,849	3,745
97	4,827	6,110	4,875	1,931	3,914
98	5,044	6,385	5,095	2,018	4,090
99	5,273	6,674	5,324	2,109	4,276

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

SOUTH CAROLINA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 294, 295, 298, 299

	Preferred				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,244	1,462	1,256	499	974
66	1,244	1,462	1,256	499	974
67	1,244	1,462	1,256	499	974
68	1,244	1,507	1,256	499	983
69	1,249	1,552	1,262	500	1,002
70	1,262	1,599	1,275	505	1,023
71	1,300	1,646	1,314	520	1,054
72	1,346	1,704	1,359	539	1,091
73	1,393	1,763	1,406	557	1,129
74	1,441	1,825	1,456	578	1,168
75	1,500	1,898	1,514	600	1,215
76	1,558	1,975	1,574	624	1,264
77	1,622	2,054	1,639	649	1,314
78	1,687	2,135	1,703	674	1,367
79	1,753	2,220	1,771	701	1,422
80	1,822	2,310	1,842	729	1,478
81	1,905	2,413	1,924	763	1,544
82	1,992	2,522	2,011	797	1,615
83	2,082	2,634	2,103	833	1,687
84	2,174	2,753	2,197	870	1,762
85	2,272	2,876	2,295	909	1,842
86	2,375	3,006	2,398	950	1,924
87	2,482	3,142	2,506	993	2,012
88	2,592	3,283	2,619	1,037	2,102
89	2,709	3,431	2,737	1,084	2,197
90	2,831	3,585	2,861	1,133	2,296
91	2,959	3,748	2,989	1,185	2,399
92	3,091	3,915	3,123	1,237	2,508
93	3,232	4,092	3,265	1,294	2,622
94	3,376	4,275	3,411	1,352	2,740
95	3,530	4,468	3,565	1,411	2,861
96	3,688	4,670	3,725	1,476	2,991
97	3,855	4,880	3,893	1,543	3,125
98	4,029	5,099	4,068	1,612	3,267
99	4,210	5,329	4,252	1,685	3,414

	Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,429	1,682	1,444	573	1,119
66	1,429	1,682	1,444	573	1,119
67	1,429	1,682	1,444	573	1,119
68	1,429	1,733	1,444	573	1,131
69	1,436	1,784	1,452	576	1,153
70	1,452	1,838	1,467	581	1,177
71	1,496	1,893	1,511	599	1,211
72	1,548	1,960	1,563	620	1,255
73	1,602	2,028	1,618	641	1,297
74	1,657	2,099	1,675	665	1,342
75	1,725	2,184	1,741	689	1,397
76	1,792	2,271	1,812	717	1,454
77	1,864	2,362	1,883	747	1,512
78	1,939	2,455	1,957	776	1,572
79	2,017	2,553	2,036	806	1,634
80	2,096	2,656	2,119	839	1,701
81	2,191	2,775	2,213	877	1,776
82	2,290	2,899	2,312	915	1,856
83	2,394	3,030	2,418	958	1,938
84	2,501	3,166	2,525	1,001	2,027
85	2,613	3,309	2,639	1,046	2,117
86	2,731	3,458	2,758	1,093	2,214
87	2,854	3,615	2,881	1,143	2,314
88	2,981	3,776	3,011	1,193	2,418
89	3,116	3,945	3,147	1,247	2,528
90	3,256	4,124	3,289	1,303	2,640
91	3,403	4,309	3,438	1,362	2,759
92	3,555	4,504	3,591	1,423	2,884
93	3,717	4,705	3,754	1,487	3,015
94	3,883	4,918	3,922	1,555	3,150
95	4,059	5,139	4,099	1,624	3,291
96	4,241	5,369	4,284	1,698	3,439
97	4,433	5,611	4,477	1,774	3,594
98	4,632	5,864	4,679	1,853	3,756
99	4,842	6,129	4,889	1,937	3,927

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

SOUTH CAROLINA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 294, 295, 298, 299

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
65	1,204	1,416	1,216	482	942
66	1,204	1,416	1,216	482	942
67	1,204	1,416	1,216	482	942
68	1,204	1,458	1,216	482	952
69	1,209	1,501	1,221	484	970
70	1,221	1,547	1,234	489	991
71	1,258	1,593	1,271	503	1,019
72	1,303	1,649	1,315	522	1,056
73	1,349	1,707	1,361	540	1,093
74	1,395	1,767	1,409	559	1,130
75	1,452	1,838	1,465	581	1,175
76	1,509	1,911	1,524	603	1,223
77	1,568	1,987	1,585	628	1,272
78	1,632	2,067	1,647	653	1,323
79	1,696	2,149	1,713	679	1,376
80	1,765	2,235	1,783	706	1,431
81	1,843	2,336	1,862	738	1,495
82	1,928	2,440	1,947	772	1,562
83	2,015	2,550	2,034	806	1,632
84	2,105	2,664	2,126	842	1,706
85	2,200	2,784	2,221	880	1,783
86	2,299	2,910	2,321	920	1,863
87	2,402	3,041	2,425	961	1,947
88	2,509	3,179	2,534	1,004	2,035
89	2,622	3,322	2,649	1,050	2,126
90	2,741	3,471	2,768	1,097	2,222
91	2,865	3,626	2,893	1,147	2,323
92	2,992	3,790	3,023	1,198	2,428
93	3,127	3,960	3,160	1,252	2,537
94	3,269	4,138	3,302	1,308	2,651
95	3,415	4,324	3,450	1,367	2,770
96	3,570	4,519	3,606	1,429	2,896
97	3,731	4,723	3,768	1,493	3,025
98	3,899	4,936	3,938	1,560	3,162
99	4,075	5,157	4,116	1,631	3,304

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
65	1,384	1,629	1,398	554	1,084
66	1,384	1,629	1,398	554	1,084
67	1,384	1,629	1,398	554	1,084
68	1,384	1,678	1,398	554	1,095
69	1,390	1,727	1,405	556	1,116
70	1,405	1,780	1,419	563	1,139
71	1,448	1,833	1,461	580	1,173
72	1,498	1,897	1,513	600	1,214
73	1,551	1,963	1,566	621	1,256
74	1,603	2,031	1,621	642	1,300
75	1,669	2,113	1,686	668	1,352
76	1,735	2,197	1,752	694	1,406
77	1,804	2,286	1,822	723	1,463
78	1,877	2,377	1,894	751	1,522
79	1,951	2,472	1,971	781	1,583
80	2,028	2,571	2,050	812	1,645
81	2,121	2,686	2,142	849	1,719
82	2,217	2,807	2,238	887	1,797
83	2,316	2,933	2,340	926	1,876
84	2,420	3,064	2,445	969	1,962
85	2,529	3,202	2,554	1,013	2,051
86	2,644	3,346	2,670	1,058	2,143
87	2,762	3,498	2,790	1,106	2,239
88	2,885	3,655	2,914	1,155	2,340
89	3,015	3,819	3,046	1,207	2,446
90	3,152	3,991	3,183	1,261	2,556
91	3,294	4,171	3,327	1,319	2,670
92	3,441	4,359	3,476	1,377	2,791
93	3,597	4,555	3,633	1,440	2,917
94	3,758	4,760	3,796	1,504	3,048
95	3,929	4,974	3,968	1,572	3,186
96	4,105	5,197	4,147	1,643	3,329
97	4,291	5,431	4,333	1,717	3,479
98	4,483	5,676	4,529	1,795	3,635
99	4,686	5,931	4,733	1,874	3,800

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

SOUTH CAROLINA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 294, 295, 298, 299

	Preferred				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,106	1,300	1,117	443	865
66	1,106	1,300	1,117	443	865
67	1,106	1,300	1,117	443	865
68	1,106	1,339	1,117	443	874
69	1,110	1,379	1,122	445	891
70	1,122	1,421	1,133	449	910
71	1,156	1,463	1,167	462	936
72	1,196	1,514	1,208	479	970
73	1,239	1,568	1,250	496	1,003
74	1,281	1,623	1,294	513	1,038
75	1,333	1,688	1,346	534	1,079
76	1,385	1,755	1,400	554	1,123
77	1,440	1,825	1,455	577	1,168
78	1,499	1,898	1,513	600	1,215
79	1,557	1,974	1,573	623	1,264
80	1,621	2,053	1,638	649	1,314
81	1,692	2,145	1,710	678	1,373
82	1,771	2,241	1,788	709	1,435
83	1,850	2,342	1,868	740	1,499
84	1,933	2,447	1,952	773	1,567
85	2,020	2,557	2,039	808	1,637
86	2,111	2,672	2,132	845	1,711
87	2,206	2,793	2,227	883	1,788
88	2,304	2,919	2,328	922	1,869
89	2,408	3,050	2,432	964	1,952
90	2,517	3,188	2,542	1,007	2,040
91	2,631	3,330	2,656	1,053	2,133
92	2,748	3,481	2,776	1,100	2,230
93	2,872	3,636	2,902	1,149	2,330
94	3,002	3,800	3,033	1,201	2,435
95	3,136	3,971	3,169	1,255	2,544
96	3,278	4,150	3,311	1,312	2,659
97	3,427	4,337	3,461	1,371	2,778
98	3,581	4,533	3,617	1,433	2,903
99	3,742	4,736	3,780	1,498	3,035

	Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,271	1,496	1,284	509	996
66	1,271	1,496	1,284	509	996
67	1,271	1,496	1,284	509	996
68	1,271	1,541	1,284	509	1,005
69	1,277	1,586	1,290	511	1,025
70	1,290	1,634	1,303	517	1,046
71	1,330	1,683	1,342	533	1,077
72	1,376	1,742	1,389	551	1,115
73	1,424	1,803	1,438	570	1,153
74	1,472	1,865	1,488	590	1,194
75	1,533	1,940	1,548	613	1,242
76	1,593	2,018	1,609	637	1,292
77	1,657	2,099	1,674	664	1,343
78	1,724	2,183	1,740	690	1,397
79	1,792	2,270	1,810	717	1,454
80	1,863	2,362	1,882	746	1,511
81	1,948	2,466	1,967	780	1,579
82	2,036	2,578	2,055	814	1,650
83	2,127	2,694	2,149	851	1,723
84	2,223	2,814	2,245	890	1,802
85	2,323	2,941	2,345	930	1,883
86	2,428	3,073	2,452	972	1,968
87	2,536	3,212	2,562	1,016	2,056
88	2,650	3,356	2,676	1,060	2,149
89	2,769	3,507	2,797	1,108	2,246
90	2,895	3,665	2,923	1,158	2,347
91	3,025	3,830	3,055	1,211	2,452
92	3,160	4,003	3,192	1,265	2,563
93	3,304	4,183	3,337	1,323	2,679
94	3,451	4,371	3,486	1,382	2,800
95	3,608	4,568	3,644	1,443	2,926
96	3,770	4,773	3,808	1,509	3,057
97	3,941	4,988	3,979	1,577	3,195
98	4,117	5,213	4,159	1,648	3,339
99	4,304	5,447	4,347	1,721	3,489

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. You will be notified, in writing, at least thirty-one (31) days in advance if a new table of rates is applicable to the policy.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and ACE Property & Casualty Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to: ACE Property & Casualty Insurance Company, Medicare Supplement Administration, P.O. Box 10858, Clearwater, Florida 33757-8858. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments, less any claims paid.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

PLAN A

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

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

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

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

PLAN A

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

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

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

PARTS A & B

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

PLAN F

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

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

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

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

PLAN F

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

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

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

(continued)

PLAN F

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN G

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

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

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

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

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

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

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

(continued)

PLAN G

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

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

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

HIGH DEDUCTIBLE PLAN G

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

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

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

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

(continued)

HIGH DEDUCTIBLE PLAN G

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

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

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

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

PLAN N

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

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

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

(continued)

PLAN N

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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