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 10-1-2024

ACE PROPERTY & CASUALTY INSURANCE COMPANY

Policy Fee $25

CALIFORNIA Standard Plans UNISEX Rates - ANNUAL

FOR USE IN ZIP CODES: 900-918, 925-929

	Preferred				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	4,458	6,781	5,298	1,694	4,014
65	1,784	2,712	2,119	678	1,605
66	1,855	2,821	2,204	705	1,669
67	1,928	2,934	2,292	734	1,736
68	2,007	3,051	2,384	762	1,807
69	2,086	3,173	2,478	792	1,878
70	2,169	3,299	2,578	825	1,953
71	2,256	3,431	2,680	858	2,030
72	2,346	3,569	2,788	893	2,111
73	2,437	3,707	2,896	928	2,193
74	2,530	3,848	3,007	962	2,277
75	2,624	3,990	3,119	999	2,361
76	2,718	4,133	3,231	1,035	2,446
77	2,813	4,278	3,345	1,071	2,532
78	2,909	4,424	3,458	1,107	2,618
79	3,005	4,570	3,572	1,144	2,705
80	3,102	4,717	3,685	1,180	2,792
81	3,198	4,864	3,799	1,216	2,879
82	3,294	5,009	3,912	1,253	2,966
83	3,393	5,159	4,029	1,290	3,054
84	3,496	5,313	4,151	1,330	3,145
85	3,600	5,473	4,275	1,369	3,240
86	3,707	5,637	4,403	1,410	3,337
87	3,819	5,806	4,536	1,453	3,438
88	3,935	5,979	4,671	1,497	3,541
89	4,053	6,159	4,812	1,541	3,648
90	4,174	6,344	4,957	1,587	3,758
91	4,299	6,534	5,105	1,634	3,870
92	4,428	6,730	5,258	1,683	3,986
93	4,561	6,932	5,416	1,734	4,107
94	4,698	7,140	5,578	1,786	4,230
95	4,838	7,355	5,746	1,839	4,356
96	4,984	7,576	5,918	1,895	4,487
97	5,134	7,803	6,096	1,951	4,621
98	5,288	8,036	6,279	2,010	4,760
99	5,447	8,278	6,467	2,070	4,903

	Standard				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	5,127	7,798	6,093	1,948	4,615
65	2,052	3,119	2,436	779	1,846
66	2,133	3,244	2,535	811	1,919
67	2,218	3,374	2,636	842	1,997
68	2,306	3,509	2,742	877	2,078
69	2,398	3,649	2,851	912	2,160
70	2,496	3,794	2,964	950	2,245
71	2,594	3,946	3,083	988	2,335
72	2,696	4,103	3,206	1,025	2,428
73	2,802	4,263	3,330	1,065	2,522
74	2,908	4,425	3,457	1,106	2,618
75	3,015	4,589	3,584	1,147	2,716
76	3,124	4,755	3,714	1,188	2,813
77	3,233	4,921	3,843	1,229	2,912
78	3,343	5,088	3,974	1,270	3,011
79	3,453	5,255	4,105	1,313	3,110
80	3,564	5,424	4,236	1,355	3,209
81	3,674	5,593	4,367	1,398	3,308
82	3,785	5,760	4,498	1,440	3,407
83	3,898	5,933	4,633	1,483	3,509
84	4,015	6,112	4,772	1,527	3,615
85	4,135	6,295	4,916	1,573	3,723
86	4,260	6,484	5,063	1,620	3,834
87	4,387	6,678	5,214	1,669	3,950
88	4,518	6,878	5,370	1,720	4,068
89	4,654	7,085	5,531	1,772	4,190
90	4,794	7,298	5,697	1,825	4,317
91	4,938	7,517	5,867	1,880	4,446
92	5,086	7,743	6,044	1,937	4,580
93	5,239	7,975	6,225	1,996	4,717
94	5,397	8,215	6,411	2,056	4,859
95	5,559	8,461	6,604	2,117	5,005
96	5,727	8,715	6,803	2,180	5,156
97	5,899	8,977	7,006	2,245	5,311
98	6,075	9,246	7,216	2,313	5,471
99	6,258	9,524	7,432	2,382	5,636

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

Effective 10-1-2024

ACE PROPERTY & CASUALTY INSURANCE COMPANY

Policy Fee $25

CALIFORNIA Standard Plans UNISEX Rates - ANNUAL

FOR USE IN ZIP CODES: 919-924, 930-949

	Preferred				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	4,098	6,232	4,869	1,557	3,689
65	1,640	2,493	1,947	624	1,476
66	1,705	2,593	2,026	648	1,534
67	1,772	2,697	2,107	674	1,596
68	1,844	2,804	2,191	700	1,660
69	1,917	2,916	2,278	728	1,726
70	1,994	3,032	2,369	758	1,795
71	2,074	3,154	2,464	789	1,866
72	2,156	3,280	2,562	821	1,940
73	2,240	3,408	2,662	853	2,016
74	2,326	3,537	2,764	885	2,093
75	2,411	3,667	2,867	918	2,170
76	2,498	3,799	2,970	951	2,248
77	2,585	3,932	3,074	985	2,327
78	2,674	4,066	3,178	1,018	2,407
79	2,762	4,201	3,283	1,051	2,486
80	2,851	4,336	3,387	1,085	2,566
81	2,939	4,470	3,492	1,118	2,646
82	3,028	4,604	3,596	1,151	2,726
83	3,119	4,742	3,703	1,186	2,807
84	3,213	4,884	3,815	1,222	2,891
85	3,309	5,030	3,930	1,259	2,978
86	3,408	5,181	4,047	1,296	3,067
87	3,510	5,336	4,169	1,335	3,160
88	3,616	5,496	4,293	1,376	3,255
89	3,725	5,661	4,423	1,417	3,353
90	3,837	5,830	4,556	1,459	3,454
91	3,951	6,006	4,692	1,502	3,557
92	4,070	6,186	4,833	1,547	3,664
93	4,192	6,371	4,978	1,594	3,774
94	4,318	6,563	5,127	1,641	3,888
95	4,447	6,760	5,281	1,691	4,004
96	4,581	6,963	5,439	1,741	4,124
97	4,718	7,172	5,603	1,794	4,248
98	4,860	7,386	5,771	1,847	4,375
99	5,007	7,608	5,944	1,902	4,507

	Standard				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	4,713	7,167	5,600	1,791	4,242
65	1,886	2,867	2,239	716	1,697
66	1,960	2,981	2,330	745	1,764
67	2,039	3,102	2,423	774	1,835
68	2,120	3,225	2,520	806	1,910
69	2,204	3,354	2,620	838	1,985
70	2,294	3,487	2,725	873	2,064
71	2,384	3,626	2,833	908	2,146
72	2,478	3,771	2,946	943	2,232
73	2,575	3,918	3,061	979	2,318
74	2,672	4,067	3,177	1,016	2,407
75	2,771	4,218	3,294	1,054	2,496
76	2,871	4,370	3,413	1,092	2,586
77	2,971	4,523	3,532	1,130	2,677
78	3,073	4,676	3,653	1,167	2,768
79	3,174	4,830	3,773	1,206	2,859
80	3,276	4,985	3,893	1,246	2,950
81	3,377	5,140	4,014	1,285	3,041
82	3,479	5,294	4,134	1,324	3,132
83	3,583	5,453	4,259	1,363	3,226
84	3,690	5,617	4,386	1,404	3,322
85	3,800	5,786	4,518	1,446	3,422
86	3,915	5,960	4,653	1,489	3,524
87	4,032	6,138	4,792	1,534	3,630
88	4,153	6,322	4,936	1,581	3,739
89	4,278	6,512	5,084	1,628	3,851
90	4,407	6,708	5,236	1,678	3,968
91	4,539	6,909	5,393	1,728	4,087
92	4,675	7,117	5,555	1,781	4,210
93	4,815	7,330	5,722	1,834	4,336
94	4,960	7,550	5,893	1,889	4,466
95	5,110	7,776	6,070	1,946	4,600
96	5,264	8,010	6,252	2,004	4,739
97	5,422	8,251	6,439	2,063	4,882
98	5,584	8,498	6,632	2,126	5,029
99	5,752	8,754	6,831	2,190	5,180

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY

CALIFORNIA Standard Plans UNISEX Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 900-949

	Preferred				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	3,770	5,734	4,480	1,433	3,394
65	1,509	2,293	1,792	574	1,358
66	1,569	2,385	1,864	596	1,412
67	1,630	2,481	1,938	620	1,468
68	1,697	2,580	2,016	644	1,528
69	1,764	2,683	2,096	670	1,588
70	1,834	2,789	2,180	698	1,651
71	1,908	2,901	2,266	726	1,717
72	1,984	3,018	2,357	755	1,785
73	2,061	3,135	2,449	784	1,855
74	2,140	3,254	2,543	814	1,926
75	2,218	3,374	2,637	844	1,996
76	2,298	3,495	2,732	875	2,069
77	2,379	3,618	2,828	906	2,141
78	2,460	3,741	2,924	936	2,214
79	2,541	3,865	3,020	967	2,287
80	2,623	3,989	3,116	998	2,361
81	2,704	4,113	3,212	1,029	2,434
82	2,785	4,235	3,308	1,059	2,508
83	2,869	4,362	3,407	1,091	2,582
84	2,956	4,493	3,510	1,125	2,660
85	3,044	4,628	3,615	1,158	2,740
86	3,135	4,766	3,723	1,193	2,822
87	3,230	4,909	3,835	1,229	2,907
88	3,327	5,056	3,950	1,266	2,995
89	3,427	5,208	4,069	1,303	3,085
90	3,530	5,364	4,191	1,342	3,177
91	3,635	5,525	4,317	1,382	3,273
92	3,745	5,691	4,446	1,423	3,371
93	3,857	5,862	4,580	1,466	3,472
94	3,973	6,038	4,717	1,510	3,577
95	4,091	6,219	4,858	1,555	3,684
96	4,214	6,406	5,004	1,602	3,794
97	4,341	6,598	5,155	1,650	3,908
98	4,472	6,795	5,309	1,700	4,025
99	4,606	6,999	5,468	1,750	4,146

	Standard				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	4,336	6,594	5,152	1,647	3,903
65	1,736	2,637	2,060	659	1,561
66	1,804	2,743	2,144	686	1,623
67	1,876	2,853	2,229	712	1,689
68	1,950	2,967	2,318	742	1,757
69	2,028	3,086	2,411	771	1,826
70	2,110	3,208	2,507	803	1,899
71	2,193	3,336	2,607	835	1,975
72	2,280	3,470	2,711	867	2,053
73	2,369	3,604	2,816	900	2,133
74	2,459	3,742	2,923	935	2,214
75	2,549	3,881	3,031	970	2,297
76	2,641	4,021	3,140	1,005	2,379
77	2,733	4,161	3,250	1,039	2,463
78	2,827	4,302	3,360	1,074	2,546
79	2,920	4,444	3,471	1,110	2,630
80	3,014	4,586	3,582	1,146	2,714
81	3,107	4,729	3,693	1,182	2,798
82	3,200	4,870	3,803	1,218	2,881
83	3,296	5,017	3,918	1,254	2,968
84	3,395	5,168	4,035	1,291	3,056
85	3,496	5,323	4,157	1,330	3,148
86	3,602	5,483	4,281	1,370	3,242
87	3,710	5,647	4,409	1,411	3,340
88	3,821	5,816	4,541	1,454	3,440
89	3,935	5,991	4,677	1,498	3,543
90	4,054	6,171	4,817	1,543	3,650
91	4,175	6,357	4,961	1,590	3,760
92	4,301	6,547	5,111	1,638	3,873
93	4,430	6,743	5,264	1,688	3,989
94	4,564	6,946	5,421	1,738	4,109
95	4,701	7,154	5,584	1,790	4,232
96	4,842	7,369	5,752	1,844	4,360
97	4,988	7,590	5,924	1,898	4,491
98	5,137	7,819	6,102	1,956	4,626
99	5,292	8,053	6,284	2,014	4,766

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, 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. For additional information concerning policy benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. Call the HICAP toll-free telephone number, 1-800-434-0222, for a referral to your local HICAP office. HICAP is a service provided free of charge by the State of California. You may also contact the Consumer Affairs department of the California Department of Insurance after first contacting your agent or the insurance company for resolution of any problems. ACE Property & Casualty Insurance Company's toll-free customer service telephone number is shown on the face page of your policy. You can contact the Consumer Affairs department at California Department of Insurance, Consumer Service Division, 300 South Spring Street, South Tower, Los Angeles, CA 90013, (800) 927-HELP (4357).

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.