

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					

¹Plans 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.

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

³Plan 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 AND CASUALTY INSURANCE COMPANY**ALABAMA Standard Plans MALE Rates - ANNUAL**

FOR USE IN ZIP CODES: 350-352

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	HD Plan G	Plan N		Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,674	1,977	1,706	677	1,267	65	1,925	2,274	1,962	779	1,457
66	1,674	1,977	1,706	677	1,267	66	1,925	2,274	1,962	779	1,457
67	1,674	1,977	1,706	677	1,267	67	1,925	2,274	1,962	779	1,457
68	1,674	2,032	1,706	677	1,273	68	1,925	2,335	1,962	779	1,464
69	1,683	2,092	1,715	679	1,290	69	1,935	2,405	1,973	782	1,485
70	1,705	2,155	1,737	689	1,314	70	1,961	2,478	1,998	792	1,512
71	1,755	2,220	1,790	709	1,354	71	2,019	2,552	2,058	816	1,556
72	1,817	2,296	1,851	734	1,401	72	2,090	2,641	2,130	845	1,612
73	1,880	2,378	1,917	760	1,449	73	2,162	2,734	2,204	873	1,668
74	1,946	2,459	1,983	786	1,500	74	2,238	2,829	2,281	904	1,725
75	2,024	2,558	2,063	817	1,560	75	2,328	2,943	2,372	940	1,795
76	2,105	2,661	2,146	851	1,622	76	2,421	3,060	2,468	979	1,865
77	2,188	2,768	2,231	884	1,688	77	2,516	3,183	2,566	1,017	1,940
78	2,277	2,878	2,320	920	1,755	78	2,618	3,309	2,669	1,058	2,019
79	2,367	2,993	2,413	956	1,826	79	2,722	3,442	2,775	1,100	2,099
80	2,462	3,112	2,511	995	1,898	80	2,832	3,580	2,887	1,144	2,182
81	2,572	3,253	2,622	1,040	1,983	81	2,958	3,740	3,016	1,196	2,282
82	2,689	3,398	2,740	1,086	2,073	82	3,091	3,908	3,151	1,249	2,383
83	2,809	3,551	2,864	1,135	2,166	83	3,230	4,084	3,293	1,305	2,491
84	2,935	3,710	2,992	1,186	2,264	84	3,376	4,267	3,441	1,364	2,603
85	3,068	3,877	3,127	1,240	2,366	85	3,527	4,460	3,596	1,425	2,720
86	3,206	4,053	3,268	1,295	2,473	86	3,687	4,661	3,758	1,490	2,844
87	3,350	4,234	3,415	1,354	2,585	87	3,851	4,871	3,927	1,556	2,971
88	3,500	4,425	3,569	1,413	2,700	88	4,025	5,089	4,104	1,627	3,105
89	3,658	4,624	3,729	1,478	2,822	89	4,207	5,317	4,288	1,699	3,247
90	3,822	4,832	3,897	1,545	2,950	90	4,395	5,558	4,481	1,777	3,391
91	3,994	5,050	4,071	1,615	3,080	91	4,594	5,809	4,682	1,856	3,545
92	4,174	5,277	4,256	1,687	3,221	92	4,800	6,071	4,894	1,940	3,702
93	4,362	5,515	4,446	1,762	3,366	93	5,016	6,343	5,113	2,027	3,870
94	4,558	5,764	4,647	1,842	3,517	94	5,242	6,629	5,344	2,118	4,045
95	4,764	6,023	4,856	1,925	3,676	95	5,478	6,927	5,584	2,213	4,228
96	4,978	6,294	5,074	2,011	3,842	96	5,724	7,238	5,835	2,313	4,417
97	5,201	6,578	5,302	2,101	4,014	97	5,981	7,564	6,098	2,417	4,617
98	5,436	6,874	5,542	2,196	4,195	98	6,251	7,905	6,373	2,525	4,824
99	5,681	7,183	5,791	2,295	4,384	99	6,533	8,261	6,660	2,639	5,041

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

ACE PROPERTY AND CASUALTY INSURANCE COMPANY**ALABAMA Standard Plans MALE Rates - ANNUAL**

FOR USE IN ZIP CODES: ALL EXCEPT 350-352

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	HD Plan G	Plan N		Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,543	1,822	1,572	624	1,168	65	1,774	2,096	1,808	718	1,343
66	1,543	1,822	1,572	624	1,168	66	1,774	2,096	1,808	718	1,343
67	1,543	1,822	1,572	624	1,168	67	1,774	2,096	1,808	718	1,343
68	1,543	1,873	1,572	624	1,173	68	1,774	2,153	1,808	718	1,350
69	1,551	1,928	1,581	626	1,189	69	1,784	2,217	1,819	721	1,369
70	1,572	1,986	1,601	635	1,211	70	1,808	2,284	1,842	730	1,393
71	1,618	2,046	1,650	654	1,248	71	1,861	2,352	1,897	752	1,434
72	1,675	2,117	1,707	677	1,291	72	1,927	2,434	1,963	778	1,486
73	1,733	2,192	1,767	701	1,336	73	1,993	2,520	2,031	805	1,537
74	1,794	2,267	1,828	725	1,383	74	2,063	2,608	2,103	833	1,590
75	1,866	2,358	1,902	753	1,438	75	2,145	2,713	2,186	867	1,654
76	1,940	2,453	1,978	784	1,495	76	2,231	2,820	2,275	902	1,719
77	2,017	2,551	2,057	815	1,556	77	2,319	2,934	2,365	938	1,788
78	2,098	2,653	2,139	848	1,618	78	2,413	3,050	2,460	975	1,861
79	2,182	2,759	2,224	881	1,683	79	2,509	3,173	2,558	1,014	1,935
80	2,269	2,869	2,314	917	1,749	80	2,610	3,300	2,661	1,054	2,011
81	2,371	2,998	2,417	958	1,828	81	2,727	3,448	2,780	1,102	2,103
82	2,478	3,132	2,526	1,001	1,911	82	2,849	3,603	2,905	1,152	2,197
83	2,590	3,273	2,640	1,046	1,997	83	2,978	3,764	3,035	1,203	2,296
84	2,705	3,420	2,758	1,093	2,087	84	3,112	3,933	3,172	1,257	2,400
85	2,828	3,574	2,883	1,143	2,181	85	3,251	4,111	3,315	1,313	2,507
86	2,955	3,735	3,012	1,194	2,279	86	3,399	4,296	3,464	1,374	2,622
87	3,088	3,903	3,147	1,248	2,382	87	3,550	4,490	3,620	1,434	2,738
88	3,226	4,079	3,289	1,303	2,489	88	3,710	4,691	3,783	1,500	2,862
89	3,371	4,262	3,437	1,362	2,601	89	3,877	4,901	3,953	1,566	2,993
90	3,523	4,454	3,592	1,424	2,719	90	4,051	5,123	4,131	1,638	3,125
91	3,682	4,655	3,753	1,488	2,839	91	4,235	5,354	4,315	1,710	3,267
92	3,848	4,864	3,923	1,555	2,968	92	4,425	5,596	4,511	1,788	3,413
93	4,021	5,084	4,098	1,624	3,102	93	4,624	5,846	4,713	1,868	3,567
94	4,201	5,313	4,283	1,698	3,242	94	4,832	6,110	4,925	1,952	3,729
95	4,391	5,552	4,476	1,774	3,389	95	5,050	6,385	5,147	2,040	3,897
96	4,588	5,801	4,677	1,853	3,541	96	5,276	6,671	5,378	2,132	4,071
97	4,794	6,064	4,887	1,937	3,700	97	5,513	6,972	5,621	2,228	4,255
98	5,011	6,336	5,108	2,024	3,867	98	5,762	7,286	5,874	2,327	4,446
99	5,236	6,620	5,338	2,116	4,041	99	6,022	7,614	6,139	2,433	4,647

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

ACE PROPERTY AND CASUALTY INSURANCE COMPANY**ALABAMA Standard Plans FEMALE Rates - ANNUAL**

FOR USE IN ZIP CODES: 350-352

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	HD Plan G	Plan N		Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,488	1,757	1,518	601	1,126	65	1,711	2,021	1,745	692	1,295
66	1,488	1,757	1,518	601	1,126	66	1,711	2,021	1,745	692	1,295
67	1,488	1,757	1,518	601	1,126	67	1,711	2,021	1,745	692	1,295
68	1,488	1,805	1,518	601	1,133	68	1,711	2,076	1,745	692	1,303
69	1,495	1,859	1,524	604	1,146	69	1,720	2,138	1,754	696	1,319
70	1,515	1,915	1,544	612	1,169	70	1,743	2,202	1,776	704	1,344
71	1,561	1,973	1,591	630	1,202	71	1,795	2,269	1,829	725	1,384
72	1,615	2,041	1,646	653	1,246	72	1,858	2,348	1,893	750	1,431
73	1,672	2,113	1,704	676	1,289	73	1,921	2,429	1,959	776	1,482
74	1,730	2,187	1,764	699	1,334	74	1,988	2,515	2,027	804	1,534
75	1,798	2,275	1,834	727	1,386	75	2,069	2,616	2,108	836	1,595
76	1,870	2,365	1,908	756	1,442	76	2,151	2,720	2,194	869	1,659
77	1,945	2,459	1,983	786	1,499	77	2,237	2,829	2,281	904	1,725
78	2,023	2,558	2,063	817	1,560	78	2,328	2,942	2,372	940	1,795
79	2,104	2,661	2,145	851	1,622	79	2,421	3,060	2,467	977	1,865
80	2,188	2,766	2,231	884	1,687	80	2,516	3,183	2,565	1,017	1,940
81	2,287	2,891	2,332	924	1,762	81	2,629	3,324	2,681	1,063	2,028
82	2,390	3,021	2,436	965	1,843	82	2,749	3,475	2,802	1,110	2,119
83	2,496	3,156	2,545	1,009	1,925	83	2,872	3,630	2,927	1,160	2,214
84	2,609	3,298	2,660	1,054	2,013	84	3,001	3,793	3,059	1,212	2,315
85	2,727	3,447	2,779	1,102	2,103	85	3,136	3,965	3,196	1,267	2,418
86	2,849	3,601	2,904	1,151	2,198	86	3,276	4,143	3,341	1,324	2,527
87	2,977	3,764	3,036	1,203	2,296	87	3,424	4,330	3,491	1,384	2,642
88	3,111	3,933	3,173	1,257	2,401	88	3,578	4,523	3,648	1,446	2,761
89	3,252	4,110	3,314	1,314	2,509	89	3,738	4,727	3,812	1,510	2,885
90	3,398	4,296	3,463	1,372	2,621	90	3,907	4,940	3,984	1,579	3,014
91	3,551	4,489	3,619	1,435	2,739	91	4,084	5,163	4,163	1,649	3,150
92	3,710	4,692	3,782	1,499	2,863	92	4,266	5,395	4,350	1,724	3,291
93	3,878	4,902	3,952	1,566	2,992	93	4,460	5,638	4,545	1,801	3,439
94	4,051	5,123	4,130	1,637	3,127	94	4,659	5,891	4,751	1,883	3,596
95	4,234	5,354	4,317	1,711	3,266	95	4,870	6,157	4,964	1,967	3,757
96	4,424	5,594	4,510	1,787	3,414	96	5,088	6,433	5,187	2,056	3,926
97	4,624	5,846	4,714	1,868	3,567	97	5,317	6,724	5,420	2,149	4,104
98	4,833	6,110	4,926	1,952	3,728	98	5,557	7,026	5,665	2,246	4,289
99	5,049	6,384	5,147	2,041	3,897	99	5,806	7,343	5,919	2,346	4,481

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

ACE PROPERTY AND CASUALTY INSURANCE COMPANY**ALABAMA Standard Plans FEMALE Rates - ANNUAL**

FOR USE IN ZIP CODES: ALL EXCEPT 350-352

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	HD Plan G	Plan N		Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,371	1,620	1,399	554	1,038	65	1,578	1,863	1,608	638	1,194
66	1,371	1,620	1,399	554	1,038	66	1,578	1,863	1,608	638	1,194
67	1,371	1,620	1,399	554	1,038	67	1,578	1,863	1,608	638	1,194
68	1,371	1,664	1,399	554	1,044	68	1,578	1,913	1,608	638	1,201
69	1,378	1,713	1,405	556	1,057	69	1,586	1,971	1,616	641	1,216
70	1,397	1,765	1,423	564	1,077	70	1,606	2,030	1,637	649	1,239
71	1,439	1,819	1,466	580	1,108	71	1,654	2,091	1,686	669	1,275
72	1,488	1,881	1,517	602	1,148	72	1,713	2,164	1,745	691	1,319
73	1,541	1,948	1,570	623	1,188	73	1,771	2,239	1,806	716	1,366
74	1,595	2,016	1,626	645	1,230	74	1,833	2,318	1,868	741	1,414
75	1,658	2,097	1,690	670	1,278	75	1,907	2,411	1,943	770	1,470
76	1,724	2,180	1,759	697	1,329	76	1,983	2,507	2,022	801	1,529
77	1,793	2,267	1,828	725	1,382	77	2,062	2,608	2,103	833	1,590
78	1,865	2,358	1,902	753	1,438	78	2,145	2,712	2,186	867	1,654
79	1,939	2,453	1,977	784	1,495	79	2,231	2,820	2,274	901	1,719
80	2,017	2,550	2,057	815	1,555	80	2,319	2,934	2,364	938	1,788
81	2,108	2,664	2,149	852	1,624	81	2,424	3,064	2,471	980	1,869
82	2,203	2,785	2,245	890	1,699	82	2,533	3,203	2,582	1,023	1,953
83	2,301	2,909	2,345	930	1,774	83	2,647	3,346	2,698	1,069	2,041
84	2,405	3,040	2,452	972	1,856	84	2,766	3,496	2,819	1,117	2,134
85	2,514	3,177	2,562	1,015	1,938	85	2,891	3,655	2,946	1,168	2,229
86	2,626	3,319	2,677	1,061	2,026	86	3,020	3,819	3,079	1,220	2,330
87	2,744	3,470	2,798	1,109	2,117	87	3,156	3,991	3,218	1,275	2,435
88	2,868	3,626	2,924	1,159	2,213	88	3,298	4,169	3,362	1,333	2,545
89	2,997	3,789	3,055	1,211	2,312	89	3,446	4,357	3,514	1,392	2,659
90	3,132	3,960	3,192	1,265	2,416	90	3,602	4,553	3,672	1,455	2,778
91	3,273	4,137	3,336	1,322	2,524	91	3,764	4,759	3,837	1,520	2,903
92	3,420	4,325	3,486	1,382	2,639	92	3,932	4,973	4,009	1,589	3,034
93	3,574	4,519	3,643	1,444	2,758	93	4,111	5,197	4,189	1,660	3,170
94	3,734	4,722	3,807	1,509	2,883	94	4,294	5,430	4,379	1,736	3,314
95	3,903	4,935	3,979	1,578	3,011	95	4,489	5,675	4,575	1,813	3,463
96	4,078	5,157	4,157	1,647	3,147	96	4,690	5,930	4,781	1,895	3,619
97	4,262	5,389	4,345	1,722	3,288	97	4,901	6,198	4,996	1,981	3,782
98	4,454	5,631	4,541	1,800	3,437	98	5,122	6,476	5,221	2,070	3,953
99	4,654	5,884	4,744	1,881	3,592	99	5,352	6,768	5,456	2,163	4,130

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

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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1676 All but \$419 a day All but \$838 a day \$0 \$0	\$0 \$419 a day \$838 a day 100% of Medicare eligible expenses \$0	\$1676 (Part A deductible) \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$209.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$209.50 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1676 All but \$419 a day All but \$838 a day \$0 \$0	\$1676 (Part A deductible) \$419 a day \$838 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$209.50 a day \$0	\$0 Up to \$209.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1676 All but \$419 a day All but \$838 a day \$0 \$0	\$1676 (Part A deductible) \$419 a day \$838 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$209.50 a day \$0	\$0 Up to \$209.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 Durable medical equipment	100%	\$0	\$0
- 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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1676 All but \$419 a day All but \$838 a day \$0 \$0	\$1676 (Part A deductible) \$419 a day \$838 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$209.50 a day \$0	\$0 Up to \$209.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 Durable medical equipment <ul style="list-style-type: none">- First \$257 of Medicare Approved Amounts*- Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$257 (Unless Part B deductible has been met) \$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 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

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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1676 All but \$419 a day All but \$838 a day \$0 \$0	\$1676 (Part A deductible) \$419 a day \$838 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$209.50 a day \$0	\$0 Up to \$209.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 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.	 \$257 (Part B deductible) 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 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

(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	100%	\$0	\$0
- First \$257 of Medicare Approved Amounts*	\$0	\$0	\$257 (Part B deductible)
- 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 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.