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.

Effective 08-01-2023

ACE PROPERTY & CASUALTY INSURANCE COMPANY

Policy Fee $25

GEORGIA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 300-303, 311, 399

	Preferred				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
0-64	17,129	20,093	17,296	6,803	12,918
65	1,713	2,009	1,730	680	1,292
66	1,713	2,009	1,730	680	1,292
67	1,713	2,009	1,730	680	1,292
68	1,713	2,009	1,730	680	1,331
69	1,750	2,052	1,767	693	1,358
70	1,786	2,098	1,805	709	1,391
71	1,826	2,143	1,844	723	1,419
72	1,874	2,198	1,892	743	1,455
73	1,923	2,256	1,942	762	1,494
74	1,974	2,315	1,993	783	1,532
75	2,025	2,375	2,045	802	1,572
76	2,079	2,435	2,099	823	1,613
77	2,140	2,512	2,163	848	1,663
78	2,207	2,589	2,229	875	1,714
79	2,275	2,667	2,297	902	1,766
80	2,344	2,750	2,367	930	1,821
81	2,415	2,835	2,440	957	1,875
82	2,489	2,918	2,514	987	1,933
83	2,575	3,022	2,601	1,021	2,001
84	2,666	3,127	2,693	1,057	2,070
85	2,760	3,239	2,788	1,093	2,145
86	2,855	3,354	2,885	1,132	2,220
87	2,956	3,469	2,987	1,173	2,298
88	3,062	3,590	3,092	1,213	2,378
89	3,166	3,717	3,199	1,256	2,464
90	3,278	3,846	3,312	1,299	2,550
91	3,392	3,983	3,428	1,345	2,639
92	3,510	4,121	3,546	1,393	2,731
93	3,634	4,264	3,671	1,440	2,825
94	3,760	4,413	3,798	1,491	2,925
95	3,891	4,568	3,930	1,543	3,026
96	4,026	4,728	4,066	1,595	3,132
97	4,170	4,897	4,213	1,652	3,244
98	4,337	5,093	4,381	1,720	3,373
99	4,512	5,295	4,557	1,789	3,510

	Standard				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
0-64	19,689	23,118	19,889	7,808	14,862
65	1,969	2,312	1,989	781	1,486
66	1,969	2,312	1,989	781	1,486
67	1,969	2,312	1,989	781	1,486
68	1,969	2,312	1,989	781	1,530
69	2,012	2,360	2,032	797	1,564
70	2,055	2,412	2,077	815	1,598
71	2,099	2,464	2,120	832	1,631
72	2,155	2,527	2,177	855	1,674
73	2,210	2,595	2,235	876	1,719
74	2,269	2,662	2,294	900	1,761
75	2,327	2,732	2,351	923	1,807
76	2,391	2,801	2,414	947	1,854
77	2,460	2,889	2,486	976	1,912
78	2,538	2,978	2,563	1,006	1,971
79	2,616	3,066	2,643	1,038	2,031
80	2,696	3,161	2,722	1,068	2,096
81	2,777	3,260	2,806	1,101	2,157
82	2,862	3,356	2,890	1,136	2,223
83	2,963	3,474	2,991	1,174	2,300
84	3,065	3,598	3,096	1,215	2,382
85	3,174	3,724	3,205	1,258	2,467
86	3,283	3,855	3,318	1,302	2,553
87	3,399	3,990	3,435	1,348	2,643
88	3,519	4,129	3,555	1,394	2,735
89	3,641	4,274	3,678	1,444	2,834
90	3,770	4,423	3,809	1,494	2,932
91	3,901	4,581	3,942	1,547	3,034
92	4,037	4,738	4,078	1,601	3,142
93	4,178	4,903	4,220	1,657	3,250
94	4,324	5,076	4,367	1,713	3,364
95	4,475	5,255	4,520	1,775	3,479
96	4,629	5,438	4,675	1,836	3,601
97	4,796	5,633	4,845	1,901	3,730
98	4,986	5,857	5,037	1,977	3,880
99	5,188	6,090	5,240	2,057	4,036

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY

GEORGIA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 300-303, 311, 399

	Preferred				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
0-64	15,498	18,179	15,649	6,155	11,688
65	1,550	1,818	1,565	616	1,169
66	1,550	1,818	1,565	616	1,169
67	1,550	1,818	1,565	616	1,169
68	1,550	1,818	1,565	616	1,204
69	1,583	1,856	1,599	627	1,229
70	1,616	1,898	1,633	641	1,259
71	1,652	1,938	1,669	654	1,283
72	1,696	1,989	1,712	672	1,316
73	1,740	2,041	1,757	690	1,352
74	1,786	2,095	1,804	708	1,386
75	1,832	2,149	1,850	725	1,423
76	1,881	2,203	1,899	745	1,459
77	1,936	2,272	1,957	768	1,505
78	1,997	2,343	2,017	791	1,551
79	2,058	2,413	2,078	816	1,598
80	2,121	2,488	2,142	842	1,648
81	2,185	2,565	2,207	865	1,696
82	2,252	2,640	2,275	893	1,749
83	2,330	2,734	2,353	924	1,810
84	2,412	2,830	2,437	956	1,873
85	2,497	2,930	2,523	989	1,940
86	2,583	3,034	2,610	1,025	2,009
87	2,675	3,139	2,703	1,061	2,079
88	2,770	3,249	2,797	1,098	2,152
89	2,865	3,363	2,894	1,136	2,229
90	2,966	3,480	2,997	1,176	2,307
91	3,069	3,603	3,102	1,217	2,388
92	3,176	3,729	3,208	1,261	2,471
93	3,288	3,858	3,321	1,303	2,556
94	3,402	3,993	3,436	1,349	2,647
95	3,520	4,133	3,556	1,396	2,738
96	3,642	4,278	3,679	1,443	2,834
97	3,773	4,430	3,811	1,495	2,935
98	3,924	4,608	3,964	1,556	3,052
99	4,082	4,791	4,123	1,618	3,175

	Standard				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
0-64	17,814	20,916	17,995	7,064	13,447
65	1,781	2,092	1,800	706	1,345
66	1,781	2,092	1,800	706	1,345
67	1,781	2,092	1,800	706	1,345
68	1,781	2,092	1,800	706	1,384
69	1,821	2,135	1,839	721	1,415
70	1,859	2,182	1,879	737	1,445
71	1,899	2,229	1,918	753	1,476
72	1,950	2,286	1,970	774	1,515
73	2,000	2,347	2,022	792	1,555
74	2,053	2,409	2,075	814	1,594
75	2,106	2,472	2,127	835	1,635
76	2,163	2,534	2,184	857	1,678
77	2,225	2,614	2,250	883	1,730
78	2,296	2,694	2,319	910	1,783
79	2,366	2,774	2,392	940	1,838
80	2,439	2,860	2,463	966	1,896
81	2,512	2,949	2,539	996	1,951
82	2,589	3,036	2,615	1,028	2,012
83	2,681	3,143	2,706	1,062	2,081
84	2,773	3,255	2,801	1,100	2,155
85	2,872	3,369	2,900	1,138	2,232
86	2,971	3,488	3,002	1,178	2,310
87	3,075	3,610	3,108	1,219	2,391
88	3,184	3,736	3,216	1,262	2,475
89	3,294	3,867	3,328	1,306	2,564
90	3,411	4,001	3,446	1,352	2,653
91	3,530	4,145	3,567	1,400	2,745
92	3,652	4,287	3,690	1,448	2,842
93	3,780	4,436	3,819	1,499	2,940
94	3,912	4,592	3,951	1,550	3,044
95	4,049	4,754	4,089	1,606	3,148
96	4,188	4,920	4,229	1,661	3,258
97	4,339	5,096	4,383	1,720	3,375
98	4,511	5,300	4,558	1,788	3,510
99	4,694	5,510	4,741	1,861	3,652

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

GEORGIA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 300-303, 311, 399

	Preferred				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
0-64	15,226	17,865	15,382	6,039	11,477
65	1,523	1,787	1,538	604	1,148
66	1,523	1,787	1,538	604	1,148
67	1,523	1,787	1,538	604	1,148
68	1,523	1,787	1,538	604	1,183
69	1,556	1,825	1,572	617	1,208
70	1,588	1,864	1,605	630	1,236
71	1,623	1,904	1,638	643	1,260
72	1,666	1,952	1,682	661	1,293
73	1,710	2,005	1,727	678	1,328
74	1,754	2,057	1,773	696	1,362
75	1,799	2,111	1,818	713	1,397
76	1,848	2,164	1,867	733	1,434
77	1,902	2,233	1,922	755	1,479
78	1,962	2,302	1,982	779	1,524
79	2,022	2,371	2,042	802	1,569
80	2,085	2,444	2,105	827	1,619
81	2,146	2,519	2,168	851	1,666
82	2,212	2,595	2,235	877	1,719
83	2,289	2,685	2,312	907	1,778
84	2,370	2,780	2,394	939	1,841
85	2,453	2,879	2,478	972	1,907
86	2,538	2,980	2,563	1,007	1,973
87	2,628	3,085	2,655	1,042	2,043
88	2,720	3,192	2,749	1,079	2,114
89	2,814	3,303	2,844	1,116	2,191
90	2,914	3,418	2,944	1,155	2,266
91	3,016	3,540	3,046	1,196	2,346
92	3,121	3,663	3,152	1,238	2,428
93	3,229	3,790	3,262	1,280	2,511
94	3,341	3,924	3,377	1,325	2,601
95	3,458	4,061	3,494	1,372	2,690
96	3,578	4,202	3,614	1,419	2,784
97	3,707	4,353	3,744	1,470	2,884
98	3,854	4,527	3,894	1,528	3,000
99	4,009	4,708	4,050	1,590	3,120

	Standard				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
0-64	17,507	20,541	17,697	6,934	13,202
65	1,751	2,054	1,770	693	1,320
66	1,751	2,054	1,770	693	1,320
67	1,751	2,054	1,770	693	1,320
68	1,751	2,054	1,770	693	1,360
69	1,789	2,099	1,806	709	1,390
70	1,828	2,144	1,845	724	1,421
71	1,867	2,191	1,884	739	1,450
72	1,915	2,246	1,936	759	1,488
73	1,966	2,305	1,987	779	1,528
74	2,018	2,366	2,039	799	1,566
75	2,068	2,429	2,090	820	1,606
76	2,126	2,490	2,145	841	1,648
77	2,187	2,567	2,209	868	1,700
78	2,256	2,647	2,279	893	1,753
79	2,325	2,726	2,348	923	1,805
80	2,397	2,811	2,420	950	1,862
81	2,469	2,897	2,494	978	1,916
82	2,543	2,983	2,570	1,009	1,977
83	2,633	3,088	2,658	1,043	2,045
84	2,725	3,198	2,752	1,081	2,117
85	2,821	3,311	2,850	1,118	2,193
86	2,918	3,427	2,948	1,158	2,269
87	3,022	3,547	3,053	1,198	2,350
88	3,128	3,671	3,161	1,241	2,431
89	3,237	3,798	3,270	1,283	2,518
90	3,350	3,930	3,385	1,329	2,607
91	3,468	4,071	3,504	1,375	2,697
92	3,587	4,213	3,625	1,423	2,792
93	3,713	4,358	3,751	1,472	2,888
94	3,844	4,511	3,883	1,523	2,990
95	3,978	4,670	4,018	1,577	3,093
96	4,115	4,833	4,156	1,631	3,201
97	4,263	5,007	4,306	1,690	3,316
98	4,433	5,207	4,478	1,757	3,450
99	4,612	5,413	4,658	1,829	3,587

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY

GEORGIA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 300-303, 311, 399

	Preferred				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
0-64	13,776	16,164	13,917	5,464	10,384
65	1,378	1,616	1,392	546	1,038
66	1,378	1,616	1,392	546	1,038
67	1,378	1,616	1,392	546	1,038
68	1,378	1,616	1,392	546	1,070
69	1,408	1,651	1,422	558	1,093
70	1,437	1,687	1,452	570	1,118
71	1,468	1,723	1,482	582	1,140
72	1,507	1,767	1,522	598	1,170
73	1,547	1,814	1,563	614	1,201
74	1,587	1,861	1,604	629	1,232
75	1,627	1,910	1,644	645	1,264
76	1,672	1,958	1,689	663	1,297
77	1,721	2,020	1,739	683	1,338
78	1,775	2,083	1,793	704	1,379
79	1,830	2,145	1,848	725	1,420
80	1,886	2,211	1,904	748	1,465
81	1,941	2,279	1,962	770	1,508
82	2,001	2,347	2,022	793	1,555
83	2,071	2,429	2,092	821	1,608
84	2,144	2,515	2,166	850	1,666
85	2,219	2,604	2,242	879	1,725
86	2,296	2,696	2,319	911	1,785
87	2,378	2,791	2,402	943	1,849
88	2,461	2,888	2,487	976	1,913
89	2,546	2,989	2,573	1,010	1,982
90	2,636	3,092	2,664	1,045	2,050
91	2,729	3,203	2,756	1,082	2,122
92	2,824	3,314	2,852	1,120	2,196
93	2,921	3,429	2,952	1,158	2,271
94	3,023	3,550	3,055	1,198	2,353
95	3,129	3,674	3,161	1,241	2,433
96	3,238	3,802	3,270	1,283	2,518
97	3,354	3,938	3,388	1,330	2,609
98	3,487	4,096	3,523	1,382	2,714
99	3,627	4,259	3,664	1,439	2,823

	Standard				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
0-64	15,840	18,584	16,011	6,274	11,945
65	1,584	1,858	1,601	627	1,194
66	1,584	1,858	1,601	627	1,194
67	1,584	1,858	1,601	627	1,194
68	1,584	1,858	1,601	627	1,230
69	1,618	1,899	1,634	641	1,258
70	1,653	1,939	1,670	655	1,285
71	1,689	1,982	1,705	669	1,312
72	1,733	2,032	1,751	687	1,347
73	1,778	2,086	1,797	704	1,382
74	1,826	2,141	1,845	723	1,417
75	1,871	2,197	1,891	742	1,453
76	1,923	2,253	1,940	761	1,491
77	1,979	2,323	1,999	785	1,538
78	2,041	2,395	2,062	808	1,586
79	2,104	2,466	2,125	835	1,633
80	2,169	2,543	2,189	860	1,685
81	2,234	2,621	2,257	885	1,734
82	2,301	2,699	2,325	913	1,788
83	2,383	2,794	2,405	944	1,851
84	2,465	2,894	2,490	978	1,916
85	2,553	2,996	2,579	1,012	1,984
86	2,640	3,100	2,668	1,047	2,053
87	2,734	3,209	2,762	1,084	2,126
88	2,830	3,322	2,860	1,122	2,199
89	2,928	3,436	2,959	1,161	2,278
90	3,031	3,556	3,062	1,202	2,358
91	3,138	3,683	3,170	1,244	2,440
92	3,246	3,812	3,280	1,287	2,526
93	3,359	3,943	3,394	1,332	2,613
94	3,478	4,081	3,513	1,378	2,705
95	3,599	4,226	3,635	1,427	2,798
96	3,723	4,373	3,760	1,476	2,896
97	3,857	4,530	3,896	1,529	3,001
98	4,011	4,711	4,051	1,590	3,121
99	4,173	4,898	4,214	1,655	3,246

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

Household Discount Factor .93

PREMIUM INFORMATION

We, ACE Property & Casualty Insurance Company, can only raise your premium if we raise the premium for all policies like yours in the same state where your policy was issued.

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* 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)

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.