

**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 <sup>1</sup>	K	L	M	N	C	F	F <sup>1</sup>
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 <sup>3</sup>	✓	✓	
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 <sup>2</sup>						\$7220 <sup>2</sup>	\$3610 <sup>2</sup>					

<sup>1</sup>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.

<sup>2</sup>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.

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

**ACE PROPERTY & CASUALTY INSURANCE COMPANY****TENNESSEE Standard Plans MALE Rates - ANNUAL**

FOR USE IN ZIP CODES: ALL OF STATE

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
0-64	6,044	7,130	6,331	2,420	4,580	0-64	6,954	8,203	7,280	2,782	5,266
65	1,511	1,782	1,583	605	1,145	65	1,739	2,051	1,820	695	1,317
66	1,511	1,782	1,583	605	1,145	66	1,739	2,051	1,820	695	1,317
67	1,511	1,782	1,583	605	1,145	67	1,739	2,051	1,820	695	1,317
68	1,511	1,837	1,583	605	1,156	68	1,739	2,112	1,820	695	1,330
69	1,520	1,892	1,592	608	1,179	69	1,748	2,175	1,830	700	1,356
70	1,535	1,949	1,607	615	1,203	70	1,765	2,241	1,848	706	1,383
71	1,580	2,007	1,655	633	1,239	71	1,816	2,308	1,903	728	1,424
72	1,635	2,077	1,713	655	1,282	72	1,881	2,390	1,970	753	1,475
73	1,693	2,150	1,772	677	1,327	73	1,945	2,472	2,038	780	1,526
74	1,753	2,225	1,836	701	1,374	74	2,015	2,558	2,111	807	1,579
75	1,822	2,314	1,909	729	1,429	75	2,096	2,662	2,195	838	1,642
76	1,894	2,407	1,986	759	1,486	76	2,178	2,768	2,284	872	1,708
77	1,972	2,504	2,065	788	1,545	77	2,268	2,878	2,374	907	1,777
78	2,050	2,603	2,147	821	1,607	78	2,357	2,993	2,470	943	1,848
79	2,132	2,706	2,233	853	1,671	79	2,451	3,113	2,568	980	1,921
80	2,216	2,816	2,322	887	1,737	80	2,550	3,237	2,671	1,020	1,999
81	2,317	2,942	2,426	927	1,816	81	2,664	3,383	2,791	1,066	2,088
82	2,421	3,074	2,536	969	1,898	82	2,784	3,534	2,916	1,114	2,182
83	2,530	3,211	2,651	1,012	1,983	83	2,909	3,693	3,048	1,165	2,279
84	2,643	3,356	2,769	1,058	2,072	84	3,039	3,859	3,185	1,217	2,383
85	2,763	3,507	2,894	1,105	2,165	85	3,178	4,033	3,328	1,270	2,490
86	2,886	3,665	3,024	1,155	2,262	86	3,320	4,216	3,477	1,328	2,602
87	3,017	3,830	3,160	1,208	2,365	87	3,468	4,406	3,633	1,389	2,719
88	3,152	4,003	3,301	1,262	2,471	88	3,625	4,603	3,797	1,451	2,842
89	3,293	4,182	3,450	1,319	2,582	89	3,787	4,811	3,968	1,515	2,971
90	3,441	4,371	3,606	1,377	2,699	90	3,958	5,027	4,146	1,585	3,103
91	3,597	4,568	3,767	1,439	2,820	91	4,137	5,253	4,333	1,655	3,243
92	3,758	4,773	3,938	1,504	2,948	92	4,321	5,490	4,527	1,730	3,389
93	3,928	4,988	4,114	1,571	3,082	93	4,516	5,736	4,730	1,807	3,543
94	4,104	5,212	4,299	1,642	3,220	94	4,719	5,995	4,944	1,889	3,703
95	4,289	5,447	4,492	1,717	3,364	95	4,933	6,264	5,166	1,973	3,869
96	4,481	5,693	4,694	1,793	3,516	96	5,154	6,545	5,399	2,062	4,042
97	4,683	5,949	4,905	1,874	3,674	97	5,386	6,840	5,641	2,155	4,225
98	4,895	6,216	5,127	1,958	3,840	98	5,627	7,149	5,895	2,251	4,416
99	5,114	6,496	5,357	2,047	4,013	99	5,881	7,471	6,162	2,353	4,615

During open enrollment and guarantee issue periods only the best rates apply. These rates will continue upon each renewal.

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

## TENNESSEE Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL OF STATE

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
0-64	5,374	6,338	5,627	2,152	4,067	0-64	6,179	7,291	6,476	2,471	4,680
65	1,343	1,584	1,407	538	1,017	65	1,545	1,823	1,619	618	1,170
66	1,343	1,584	1,407	538	1,017	66	1,545	1,823	1,619	618	1,170
67	1,343	1,584	1,407	538	1,017	67	1,545	1,823	1,619	618	1,170
68	1,343	1,633	1,407	538	1,028	68	1,545	1,877	1,619	618	1,182
69	1,351	1,682	1,415	541	1,048	69	1,553	1,933	1,627	622	1,206
70	1,364	1,732	1,428	546	1,070	70	1,569	1,993	1,643	628	1,229
71	1,404	1,784	1,471	562	1,101	71	1,614	2,052	1,692	647	1,266
72	1,453	1,846	1,522	581	1,140	72	1,672	2,123	1,751	670	1,311
73	1,505	1,911	1,576	602	1,180	73	1,730	2,197	1,812	692	1,356
74	1,558	1,978	1,631	623	1,221	74	1,792	2,273	1,876	717	1,403
75	1,619	2,056	1,697	648	1,269	75	1,863	2,366	1,951	745	1,460
76	1,684	2,139	1,765	674	1,320	76	1,937	2,460	2,030	775	1,518
77	1,753	2,225	1,836	701	1,374	77	2,015	2,558	2,111	807	1,580
78	1,822	2,314	1,909	730	1,429	78	2,096	2,661	2,196	839	1,642
79	1,894	2,406	1,985	758	1,486	79	2,178	2,766	2,283	871	1,708
80	1,970	2,503	2,064	788	1,545	80	2,267	2,878	2,374	907	1,776
81	2,060	2,614	2,156	825	1,614	81	2,368	3,007	2,480	948	1,856
82	2,152	2,732	2,255	862	1,686	82	2,474	3,141	2,593	991	1,940
83	2,249	2,855	2,355	900	1,762	83	2,586	3,283	2,710	1,034	2,026
84	2,349	2,982	2,461	940	1,842	84	2,702	3,431	2,831	1,082	2,118
85	2,456	3,118	2,573	982	1,925	85	2,825	3,585	2,958	1,129	2,213
86	2,566	3,257	2,688	1,027	2,011	86	2,951	3,747	3,090	1,181	2,313
87	2,681	3,405	2,809	1,073	2,102	87	3,083	3,916	3,229	1,235	2,417
88	2,802	3,558	2,934	1,121	2,196	88	3,222	4,092	3,374	1,290	2,526
89	2,927	3,718	3,067	1,171	2,296	89	3,366	4,276	3,527	1,347	2,641
90	3,059	3,886	3,205	1,224	2,399	90	3,518	4,468	3,686	1,408	2,759
91	3,197	4,060	3,348	1,280	2,507	91	3,677	4,670	3,851	1,471	2,883
92	3,341	4,242	3,500	1,337	2,620	92	3,842	4,880	4,024	1,538	3,013
93	3,491	4,434	3,657	1,396	2,739	93	4,014	5,099	4,204	1,606	3,150
94	3,648	4,634	3,822	1,460	2,862	94	4,195	5,328	4,395	1,680	3,292
95	3,812	4,842	3,993	1,526	2,990	95	4,384	5,568	4,593	1,754	3,440
96	3,983	5,060	4,173	1,594	3,125	96	4,581	5,818	4,798	1,832	3,594
97	4,163	5,287	4,361	1,666	3,266	97	4,787	6,081	5,015	1,916	3,756
98	4,350	5,525	4,558	1,740	3,413	98	5,002	6,354	5,241	2,002	3,925
99	4,546	5,774	4,762	1,819	3,567	99	5,228	6,641	5,477	2,092	4,102

During open enrollment and guarantee issue periods only the best rates apply. These rates will continue upon each renewal.

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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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
<b>SKILLED NURSING FACILITY CARE*</b> 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 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> 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
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES –</b> 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
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY</b> <b>SERVICES – TESTS FOR DIAGNOSTIC</b> <b>SERVICES</b>	100%	\$0	\$0

## PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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
<b>SKILLED NURSING FACILITY CARE*</b> 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 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> 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
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES –</b> 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
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY SERVICES –</b> <b>TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

(continued)



**PLAN F**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> 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
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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
<b>SKILLED NURSING FACILITY CARE*</b> 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 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> 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
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES –</b> 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
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**PLAN G**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> 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
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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
<b>SKILLED NURSING FACILITY CARE*</b> 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 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> 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
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES –</b> 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
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY SERVICES –</b> 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
<b>HOME HEALTH CARE</b> 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	AFTER YOU PAY \$2870 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO \$2870 DEDUCTIBLE ** YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> 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
<b>SKILLED NURSING FACILITY CARE*</b> 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 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> 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
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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
<b>MEDICAL EXPENSES –</b> 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.
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> 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
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

**PLAN N**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> 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
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> 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.