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

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

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

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

Benefits	Plans Available to All Applicants									Medicare first eligible before 2020 only		
	A	B	D	G	G[1]	K	L	M	N	C	F	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Medicare Part B coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓ copays apply[3]	✓	✓	
Blood (first three pints)	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Part A hospice care coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Skilled nursing facility coinsurance			✓	✓		50%	75%	✓	✓	✓	✓	
Medicare Part A deductible		✓	✓	✓		50%	75%	50%	✓	✓	✓	
Medicare Part B deductible										✓	✓	
Medicare Part B excess charges				✓							✓	
Foreign travel emergency (up to plan limits)			✓	✓				✓	✓	✓	✓	
Out-of-pocket limit in 2025[2]						$7220[2]	$3610[2]					

[1]Plans F and G also have a high deductible option which requires first paying a plan deductible of $2870 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY

MISSISSIPPI Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 394, 395

	Preferred						Standard				
				HD Plan						HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N	Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	6,359	7,641	6,658	2,476	4,729	0-64	7,312	8,790	7,656	2,848	5,438
65	1,590	1,910	1,665	619	1,182	65	1,828	2,197	1,914	712	1,359
66	1,590	1,910	1,665	619	1,182	66	1,828	2,197	1,914	712	1,359
67	1,590	1,910	1,665	619	1,182	67	1,828	2,197	1,914	712	1,359
68	1,590	1,964	1,665	619	1,188	68	1,828	2,257	1,914	712	1,366
69	1,598	2,022	1,673	621	1,204	69	1,837	2,325	1,925	715	1,386
70	1,619	2,082	1,695	630	1,227	70	1,862	2,395	1,950	725	1,411
71	1,666	2,145	1,747	648	1,263	71	1,918	2,466	2,008	746	1,453
72	1,725	2,219	1,806	671	1,307	72	1,985	2,552	2,078	772	1,504
73	1,786	2,298	1,870	695	1,353	73	2,053	2,642	2,150	798	1,556
74	1,848	2,377	1,935	719	1,400	74	2,125	2,734	2,226	827	1,609
75	1,922	2,472	2,013	747	1,456	75	2,210	2,844	2,314	860	1,674
76	1,999	2,572	2,094	778	1,514	76	2,299	2,957	2,408	895	1,741
77	2,078	2,675	2,177	809	1,575	77	2,389	3,076	2,504	930	1,810
78	2,162	2,781	2,264	842	1,638	78	2,486	3,198	2,604	968	1,884
79	2,248	2,893	2,354	874	1,704	79	2,585	3,326	2,708	1,006	1,958
80	2,337	3,008	2,450	910	1,771	80	2,689	3,460	2,817	1,046	2,036
81	2,442	3,144	2,559	951	1,851	81	2,809	3,615	2,943	1,094	2,128
82	2,553	3,284	2,674	993	1,934	82	2,935	3,777	3,075	1,142	2,224
83	2,668	3,432	2,795	1,038	2,022	83	3,068	3,947	3,213	1,194	2,325
84	2,787	3,586	2,919	1,085	2,112	84	3,205	4,124	3,357	1,247	2,429
85	2,913	3,747	3,051	1,133	2,208	85	3,349	4,310	3,509	1,303	2,538
86	3,044	3,916	3,188	1,185	2,308	86	3,502	4,504	3,667	1,363	2,654
87	3,181	4,092	3,332	1,238	2,411	87	3,657	4,707	3,832	1,423	2,772
88	3,323	4,276	3,482	1,292	2,519	88	3,822	4,918	4,004	1,488	2,897
89	3,473	4,469	3,639	1,351	2,633	89	3,994	5,139	4,184	1,554	3,029
90	3,629	4,670	3,802	1,413	2,752	90	4,174	5,371	4,372	1,625	3,164
91	3,793	4,881	3,972	1,476	2,874	91	4,362	5,614	4,568	1,697	3,307
92	3,964	5,100	4,152	1,542	3,005	92	4,558	5,867	4,775	1,774	3,455
93	4,142	5,330	4,338	1,612	3,140	93	4,763	6,130	4,989	1,853	3,611
94	4,328	5,570	4,534	1,684	3,282	94	4,978	6,406	5,214	1,936	3,774
95	4,524	5,821	4,738	1,760	3,430	95	5,202	6,694	5,449	2,024	3,944
96	4,727	6,082	4,951	1,839	3,584	96	5,436	6,995	5,693	2,115	4,121
97	4,939	6,357	5,173	1,922	3,745	97	5,680	7,310	5,950	2,210	4,308
98	5,162	6,643	5,407	2,008	3,915	98	5,936	7,639	6,218	2,309	4,501
99	5,394	6,941	5,650	2,099	4,091	99	6,203	7,983	6,498	2,413	4,704

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

Household Discount Factor 0.93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

MISSISSIPPI Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 394, 395

	Preferred				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	5,870	7,054	6,146	2,285	4,365
65	1,467	1,763	1,537	571	1,091
66	1,467	1,763	1,537	571	1,091
67	1,467	1,763	1,537	571	1,091
68	1,467	1,813	1,537	571	1,097
69	1,475	1,866	1,544	573	1,111
70	1,495	1,922	1,565	582	1,132
71	1,538	1,980	1,612	599	1,166
72	1,593	2,049	1,667	620	1,207
73	1,648	2,121	1,726	642	1,249
74	1,706	2,194	1,786	664	1,293
75	1,774	2,282	1,858	690	1,344
76	1,845	2,374	1,933	718	1,397
77	1,918	2,469	2,010	746	1,454
78	1,995	2,567	2,090	777	1,512
79	2,075	2,670	2,173	807	1,572
80	2,158	2,777	2,261	840	1,634
81	2,255	2,902	2,362	877	1,709
82	2,357	3,031	2,468	916	1,785
83	2,463	3,168	2,580	958	1,866
84	2,572	3,310	2,695	1,001	1,950
85	2,689	3,459	2,817	1,046	2,038
86	2,810	3,615	2,943	1,093	2,130
87	2,936	3,777	3,075	1,143	2,226
88	3,068	3,947	3,214	1,193	2,325
89	3,206	4,125	3,359	1,248	2,430
90	3,350	4,311	3,510	1,304	2,540
91	3,501	4,505	3,667	1,363	2,653
92	3,659	4,708	3,833	1,424	2,774
93	3,823	4,920	4,004	1,488	2,899
94	3,995	5,142	4,185	1,555	3,030
95	4,176	5,373	4,374	1,625	3,166
96	4,363	5,615	4,570	1,697	3,308
97	4,559	5,868	4,776	1,774	3,457
98	4,765	6,132	4,991	1,853	3,614
99	4,979	6,407	5,216	1,937	3,776

	Standard				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	6,750	8,114	7,067	2,629	5,019
65	1,687	2,028	1,767	657	1,255
66	1,687	2,028	1,767	657	1,255
67	1,687	2,028	1,767	657	1,255
68	1,687	2,083	1,767	657	1,261
69	1,696	2,146	1,777	660	1,279
70	1,719	2,211	1,800	669	1,302
71	1,770	2,277	1,854	689	1,341
72	1,832	2,356	1,918	713	1,388
73	1,895	2,439	1,985	737	1,436
74	1,962	2,524	2,055	763	1,485
75	2,040	2,626	2,136	794	1,545
76	2,122	2,730	2,223	826	1,607
77	2,206	2,839	2,311	859	1,671
78	2,295	2,952	2,404	893	1,739
79	2,386	3,071	2,500	929	1,807
80	2,482	3,194	2,600	966	1,880
81	2,593	3,337	2,716	1,010	1,965
82	2,710	3,487	2,838	1,055	2,053
83	2,832	3,643	2,966	1,102	2,146
84	2,959	3,806	3,099	1,151	2,242
85	3,092	3,979	3,239	1,202	2,343
86	3,232	4,158	3,385	1,258	2,450
87	3,376	4,345	3,537	1,314	2,559
88	3,528	4,540	3,696	1,373	2,674
89	3,687	4,743	3,862	1,434	2,796
90	3,853	4,958	4,036	1,500	2,921
91	4,027	5,182	4,217	1,566	3,053
92	4,208	5,415	4,407	1,637	3,189
93	4,397	5,658	4,605	1,711	3,334
94	4,595	5,913	4,813	1,787	3,484
95	4,802	6,179	5,030	1,868	3,641
96	5,018	6,457	5,255	1,952	3,804
97	5,243	6,747	5,492	2,040	3,976
98	5,479	7,051	5,740	2,131	4,154
99	5,726	7,369	5,998	2,228	4,342

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

Household Discount Factor 0.93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

MISSISSIPPI Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 394, 395

	Preferred				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	5,651	6,793	5,924	2,199	4,202
65	1,413	1,698	1,481	550	1,051
66	1,413	1,698	1,481	550	1,051
67	1,413	1,698	1,481	550	1,051
68	1,413	1,744	1,481	550	1,057
69	1,420	1,796	1,487	552	1,070
70	1,439	1,851	1,507	560	1,090
71	1,482	1,907	1,552	576	1,122
72	1,533	1,972	1,606	597	1,162
73	1,587	2,042	1,662	618	1,203
74	1,643	2,114	1,721	639	1,245
75	1,708	2,199	1,789	664	1,294
76	1,776	2,286	1,861	692	1,346
77	1,847	2,377	1,935	719	1,399
78	1,921	2,472	2,013	747	1,456
79	1,998	2,572	2,093	778	1,514
80	2,078	2,674	2,177	809	1,574
81	2,171	2,793	2,275	845	1,644
82	2,269	2,919	2,376	882	1,719
83	2,371	3,050	2,483	922	1,797
84	2,478	3,187	2,595	964	1,878
85	2,590	3,331	2,711	1,007	1,962
86	2,705	3,480	2,834	1,053	2,051
87	2,827	3,638	2,962	1,100	2,143
88	2,954	3,801	3,096	1,149	2,240
89	3,088	3,972	3,234	1,202	2,341
90	3,227	4,151	3,379	1,255	2,445
91	3,372	4,338	3,531	1,312	2,555
92	3,523	4,534	3,690	1,371	2,671
93	3,682	4,738	3,856	1,432	2,792
94	3,847	4,951	4,030	1,497	2,918
95	4,020	5,174	4,212	1,565	3,048
96	4,201	5,406	4,401	1,634	3,186
97	4,391	5,650	4,600	1,708	3,329
98	4,589	5,904	4,807	1,785	3,479
99	4,794	6,170	5,022	1,866	3,636

	Standard				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	6,501	7,811	6,810	2,530	4,833
65	1,625	1,953	1,702	633	1,208
66	1,625	1,953	1,702	633	1,208
67	1,625	1,953	1,702	633	1,208
68	1,625	2,006	1,702	633	1,215
69	1,633	2,067	1,711	636	1,231
70	1,655	2,128	1,733	644	1,254
71	1,704	2,193	1,784	663	1,291
72	1,764	2,269	1,847	686	1,336
73	1,824	2,348	1,912	710	1,382
74	1,888	2,430	1,978	735	1,431
75	1,965	2,528	2,057	764	1,488
76	2,043	2,629	2,140	795	1,548
77	2,124	2,734	2,226	827	1,609
78	2,210	2,843	2,314	860	1,674
79	2,299	2,957	2,407	894	1,741
80	2,389	3,076	2,502	930	1,810
81	2,497	3,213	2,616	972	1,892
82	2,610	3,358	2,733	1,015	1,977
83	2,727	3,508	2,856	1,061	2,066
84	2,849	3,666	2,984	1,108	2,160
85	2,978	3,832	3,119	1,158	2,257
86	3,111	4,004	3,259	1,211	2,359
87	3,251	4,184	3,406	1,265	2,464
88	3,398	4,371	3,559	1,322	2,576
89	3,550	4,568	3,719	1,381	2,692
90	3,710	4,774	3,887	1,443	2,813
91	3,878	4,990	4,062	1,508	2,939
92	4,051	5,214	4,244	1,576	3,071
93	4,235	5,449	4,435	1,647	3,209
94	4,424	5,694	4,635	1,722	3,355
95	4,624	5,950	4,843	1,799	3,506
96	4,832	6,217	5,061	1,880	3,664
97	5,049	6,498	5,288	1,965	3,828
98	5,276	6,790	5,527	2,053	4,001
99	5,514	7,096	5,775	2,145	4,182

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

Household Discount Factor 0.93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

MISSISSIPPI Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 394, 395

	Preferred				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	5,217	6,271	5,469	2,030	3,879
65	1,304	1,568	1,367	507	970
66	1,304	1,568	1,367	507	970
67	1,304	1,568	1,367	507	970
68	1,304	1,610	1,367	507	976
69	1,311	1,658	1,373	509	988
70	1,328	1,709	1,391	517	1,006
71	1,368	1,760	1,433	531	1,036
72	1,415	1,820	1,482	551	1,072
73	1,465	1,885	1,534	570	1,110
74	1,516	1,951	1,588	590	1,149
75	1,576	2,030	1,652	613	1,194
76	1,639	2,110	1,718	638	1,242
77	1,705	2,194	1,786	664	1,292
78	1,773	2,282	1,858	690	1,344
79	1,844	2,374	1,932	718	1,397
80	1,918	2,468	2,010	746	1,453
81	2,004	2,579	2,100	780	1,518
82	2,095	2,695	2,194	815	1,587
83	2,188	2,816	2,292	851	1,658
84	2,287	2,942	2,396	890	1,734
85	2,391	3,075	2,503	930	1,812
86	2,497	3,213	2,616	972	1,893
87	2,609	3,358	2,734	1,016	1,978
88	2,727	3,509	2,857	1,061	2,067
89	2,850	3,667	2,985	1,109	2,161
90	2,979	3,832	3,119	1,158	2,257
91	3,112	4,004	3,259	1,211	2,359
92	3,252	4,185	3,406	1,265	2,466
93	3,399	4,373	3,560	1,322	2,577
94	3,551	4,570	3,720	1,382	2,693
95	3,711	4,776	3,888	1,445	2,814
96	3,878	4,991	4,062	1,509	2,941
97	4,053	5,215	4,246	1,577	3,073
98	4,236	5,450	4,437	1,648	3,211
99	4,425	5,695	4,636	1,722	3,357

	Standard				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	6,001	7,210	6,286	2,336	4,462
65	1,500	1,803	1,572	584	1,115
66	1,500	1,803	1,572	584	1,115
67	1,500	1,803	1,572	584	1,115
68	1,500	1,852	1,572	584	1,122
69	1,508	1,908	1,579	587	1,136
70	1,527	1,965	1,600	594	1,157
71	1,573	2,024	1,647	612	1,192
72	1,629	2,094	1,705	633	1,233
73	1,684	2,167	1,765	655	1,276
74	1,743	2,243	1,826	678	1,321
75	1,814	2,334	1,899	706	1,373
76	1,886	2,427	1,976	734	1,429
77	1,961	2,524	2,055	763	1,485
78	2,040	2,624	2,136	794	1,545
79	2,122	2,730	2,222	825	1,607
80	2,206	2,839	2,310	859	1,671
81	2,305	2,965	2,415	897	1,746
82	2,409	3,100	2,523	937	1,825
83	2,517	3,238	2,636	979	1,907
84	2,630	3,384	2,755	1,023	1,994
85	2,749	3,537	2,879	1,069	2,083
86	2,872	3,696	3,009	1,118	2,177
87	3,001	3,862	3,144	1,168	2,275
88	3,136	4,034	3,285	1,220	2,378
89	3,277	4,217	3,433	1,275	2,485
90	3,425	4,407	3,588	1,332	2,597
91	3,579	4,606	3,749	1,392	2,713
92	3,739	4,813	3,917	1,455	2,835
93	3,909	5,030	4,094	1,520	2,963
94	4,083	5,256	4,279	1,589	3,097
95	4,269	5,493	4,471	1,661	3,236
96	4,460	5,739	4,672	1,735	3,382
97	4,660	5,998	4,882	1,814	3,534
98	4,871	6,268	5,102	1,895	3,693
99	5,089	6,550	5,331	1,980	3,860

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

Household Discount Factor 0.93

PREMIUM INFORMATION

ACE Property & Casualty Insurance Company may change your premium on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class. Class is defined as attained age, sex, underwriting class, state of issue, and your most recent zip code of residence in the state of issue. Premiums are based on your attained age and will change on your policy anniversary date.

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 $1676	$0	$1676 (Part A deductible)
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	$0	Up to $209.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN A

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

*Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 Generally 80%	$0 Generally 20%	$257 (Part B deductible) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 $0 80%	All costs $0 20%	$0 $257 (Part B deductible) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $257 (Part B deductible) $0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1676	$1676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN F

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

*Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $257 (Part B deductible) Generally 20%	 $0 $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $257 of Medicare Approved amounts* Remainder of Medicare Approved amounts	 $0 $0 80%	 All costs $257 (Part B deductible) 20%	 $0 $0 $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	$0	$0
- First $257 of Medicare Approved Amounts*	$0	$257 (Part B deductible)	$0
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1676	$1676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

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

*Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 $257 (Unless Part B deductible has been met) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 $257 (Unless Part B deductible has been met) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment - First $257 of Medicare Approved Amounts*	$0	$0	$257 (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. **This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2870 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2870. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2870 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2870 DEDUCTIBLE ** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1676	$1676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0***
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

HIGH DEDUCTIBLE PLAN G

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

*Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2870 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2870. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2870 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2870 DEDUCTIBLE ** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	$0 Generally 80%	$0 Generally 20%	$257 (Unless Part B deductible has been met) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $257 of Medicare Approved amounts* Remainder of Medicare Approved amounts	$0 $0 80%	All costs $0 20%	$0 $257 (Unless Part B deductible has been met) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2870 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2870 DEDUCTIBLE ** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment - First $257 of Medicare Approved Amounts*	$0	$0	$257 (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2870 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2870 DEDUCTIBLE ** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1676	$1676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN N

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

*Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $257 of Medicare Approved Amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $257 of Medicare Approved Amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment - First $257 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $257 (Part B deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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