

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

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

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

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

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

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

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

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

MONTANA 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	HD Plan G	Plan N		Plan A	Plan F	Plan G	HD Plan G	Plan N
Under 65	6,721	8,404	6,851	2,714	5,346	Under 65	7,727	9,669	7,877	3,126	6,145
65	1,680	2,101	1,713	679	1,337	65	1,932	2,417	1,969	781	1,536
66	1,680	2,101	1,713	679	1,337	66	1,932	2,417	1,969	781	1,536
67	1,680	2,101	1,713	679	1,337	67	1,932	2,417	1,969	781	1,536
68	1,680	2,185	1,713	679	1,337	68	1,932	2,514	1,969	781	1,536
69	1,680	2,273	1,713	679	1,337	69	1,932	2,614	1,969	781	1,536
70	1,747	2,363	1,781	706	1,390	70	2,010	2,718	2,050	813	1,598
71	1,808	2,446	1,843	731	1,438	71	2,079	2,813	2,119	841	1,654
72	1,854	2,506	1,890	749	1,473	72	2,131	2,882	2,173	861	1,695
73	1,899	2,570	1,936	768	1,511	73	2,186	2,954	2,228	883	1,738
74	1,947	2,633	1,985	786	1,548	74	2,239	3,029	2,283	905	1,782
75	1,995	2,698	2,034	806	1,586	75	2,295	3,102	2,339	927	1,825
76	2,045	2,766	2,085	826	1,626	76	2,351	3,181	2,398	950	1,870
77	2,096	2,835	2,138	847	1,667	77	2,411	3,260	2,457	975	1,916
78	2,148	2,906	2,190	868	1,708	78	2,470	3,341	2,519	999	1,966
79	2,203	2,980	2,245	890	1,752	79	2,533	3,427	2,582	1,023	2,014
80	2,247	3,039	2,291	907	1,787	80	2,584	3,494	2,634	1,044	2,055
81	2,292	3,100	2,337	925	1,822	81	2,636	3,564	2,687	1,064	2,096
82	2,337	3,162	2,383	945	1,859	82	2,688	3,637	2,739	1,086	2,137
83	2,384	3,224	2,431	963	1,895	83	2,743	3,709	2,797	1,108	2,180
84	2,433	3,289	2,479	982	1,934	84	2,798	3,782	2,852	1,130	2,223
85	2,468	3,339	2,516	998	1,963	85	2,838	3,841	2,893	1,147	2,257
86	2,504	3,386	2,553	1,011	1,991	86	2,880	3,896	2,936	1,164	2,290
87	2,543	3,438	2,592	1,027	2,021	87	2,924	3,954	2,980	1,182	2,325
88	2,579	3,489	2,630	1,043	2,051	88	2,966	4,013	3,024	1,199	2,360
89	2,619	3,543	2,670	1,058	2,083	89	3,013	4,075	3,072	1,217	2,395
90	2,659	3,594	2,710	1,074	2,113	90	3,057	4,134	3,117	1,234	2,430
91	2,697	3,650	2,750	1,090	2,146	91	3,103	4,197	3,163	1,253	2,468
92	2,739	3,705	2,792	1,107	2,178	92	3,150	4,261	3,211	1,272	2,505
93	2,780	3,759	2,833	1,123	2,210	93	3,196	4,322	3,258	1,292	2,540
94	2,821	3,815	2,876	1,139	2,243	94	3,244	4,388	3,307	1,310	2,580
95	2,863	3,872	2,919	1,156	2,276	95	3,294	4,452	3,357	1,331	2,619
96	2,907	3,930	2,963	1,173	2,310	96	3,342	4,518	3,407	1,350	2,656
97	2,949	3,988	3,007	1,191	2,344	97	3,392	4,588	3,457	1,370	2,697
98	2,994	4,049	3,052	1,210	2,380	98	3,441	4,656	3,509	1,391	2,739
99	3,039	4,108	3,097	1,228	2,416	99	3,493	4,724	3,561	1,412	2,777

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY**MONTANA 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	HD Plan G	Plan N		Plan A	Plan F	Plan G	HD Plan G	Plan N
Under 65	5,975	7,471	6,089	2,414	4,751	Under 65	6,871	8,594	7,003	2,777	5,463
65	1,494	1,868	1,522	604	1,188	65	1,718	2,149	1,751	694	1,366
66	1,494	1,868	1,522	604	1,188	66	1,718	2,149	1,751	694	1,366
67	1,494	1,868	1,522	604	1,188	67	1,718	2,149	1,751	694	1,366
68	1,494	1,942	1,522	604	1,188	68	1,718	2,234	1,751	694	1,366
69	1,494	2,020	1,522	604	1,188	69	1,718	2,323	1,751	694	1,366
70	1,553	2,101	1,583	628	1,235	70	1,787	2,416	1,821	722	1,420
71	1,608	2,174	1,638	650	1,279	71	1,848	2,500	1,884	748	1,470
72	1,647	2,228	1,680	665	1,310	72	1,894	2,562	1,931	766	1,506
73	1,689	2,284	1,721	682	1,343	73	1,943	2,626	1,980	785	1,545
74	1,731	2,341	1,764	699	1,377	74	1,990	2,692	2,029	804	1,583
75	1,773	2,399	1,808	716	1,410	75	2,039	2,758	2,079	824	1,622
76	1,818	2,459	1,853	734	1,445	76	2,091	2,827	2,132	844	1,662
77	1,863	2,520	1,900	752	1,482	77	2,142	2,897	2,184	866	1,703
78	1,910	2,583	1,947	772	1,519	78	2,197	2,970	2,239	888	1,747
79	1,958	2,649	1,996	791	1,557	79	2,251	3,046	2,295	910	1,790
80	1,997	2,700	2,036	807	1,588	80	2,297	3,106	2,341	928	1,826
81	2,037	2,755	2,077	823	1,620	81	2,342	3,168	2,388	946	1,863
82	2,078	2,810	2,118	839	1,652	82	2,389	3,233	2,435	965	1,900
83	2,119	2,866	2,161	856	1,685	83	2,439	3,296	2,486	985	1,938
84	2,162	2,924	2,204	873	1,719	84	2,486	3,362	2,534	1,004	1,976
85	2,194	2,968	2,237	887	1,744	85	2,523	3,413	2,572	1,020	2,007
86	2,226	3,010	2,269	899	1,770	86	2,561	3,462	2,610	1,034	2,036
87	2,260	3,056	2,304	913	1,796	87	2,598	3,515	2,649	1,050	2,066
88	2,293	3,102	2,338	927	1,824	88	2,637	3,567	2,688	1,066	2,097
89	2,328	3,150	2,373	941	1,852	89	2,678	3,622	2,730	1,081	2,129
90	2,362	3,195	2,409	954	1,879	90	2,717	3,675	2,770	1,097	2,160
91	2,399	3,244	2,445	969	1,908	91	2,758	3,731	2,812	1,114	2,193
92	2,435	3,294	2,482	983	1,937	92	2,800	3,787	2,854	1,131	2,227
93	2,470	3,340	2,519	998	1,964	93	2,840	3,842	2,896	1,148	2,258
94	2,508	3,391	2,556	1,014	1,993	94	2,884	3,900	2,940	1,165	2,293
95	2,545	3,443	2,594	1,028	2,024	95	2,927	3,958	2,984	1,183	2,327
96	2,582	3,493	2,633	1,044	2,054	96	2,971	4,016	3,029	1,200	2,361
97	2,621	3,545	2,672	1,060	2,084	97	3,014	4,077	3,073	1,218	2,397
98	2,661	3,599	2,713	1,075	2,116	98	3,059	4,139	3,119	1,236	2,434
99	2,700	3,651	2,753	1,091	2,147	99	3,105	4,200	3,166	1,254	2,469

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. We will give You advance written notice at least forty-five (45) days prior to any premium change. We will not increase the premiums more frequently than once in a twelve (12) month period.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and ACE Property & Casualty Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to: ACE Property & Casualty Insurance Company, Medicare Supplement Administration, P.O. Box 10858, Clearwater, Florida 33757-8858. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments, less any claims paid.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither ACE Property & Casualty Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. ACE Property & Casualty Insurance Company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded. Please refer to your policy for details.

PLAN A

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

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

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

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

PLAN A

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

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

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

PARTS A & B

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

PLAN F

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

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

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

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

PLAN F

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

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

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

(continued)

PLAN F
PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN G

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

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

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

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

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

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

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

(continued)

PLAN G
PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

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

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

HIGH DEDUCTIBLE PLAN G

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

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

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

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

(continued)

HIGH DEDUCTIBLE PLAN G

PARTS A & B

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

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

PLAN N

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

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

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

(continued)

PLAN N
PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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