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.

Effective 8-1-2024

ACE PROPERTY & CASUALTY INSURANCE COMPANY

WEST VIRGINIA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL OF STATE

	Preferred						Standard					
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
65	1,544	1,806	1,573	618	1,181	65	1,775	2,077	1,809	711	1,358
66	1,544	1,806	1,573	618	1,181	66	1,775	2,077	1,809	711	1,358
67	1,544	1,806	1,573	618	1,181	67	1,775	2,077	1,809	711	1,358
68	1,544	1,856	1,573	618	1,187	68	1,775	2,133	1,809	711	1,365
69	1,552	1,911	1,581	621	1,202	69	1,784	2,197	1,819	715	1,384
70	1,573	1,968	1,602	630	1,225	70	1,808	2,264	1,843	724	1,409
71	1,618	2,028	1,651	648	1,261	71	1,862	2,331	1,898	745	1,451
72	1,676	2,098	1,707	670	1,306	72	1,928	2,412	1,964	771	1,502
73	1,734	2,172	1,767	694	1,351	73	1,994	2,497	2,032	798	1,554
74	1,795	2,246	1,829	718	1,399	74	2,064	2,584	2,104	826	1,607
75	1,867	2,337	1,903	746	1,454	75	2,146	2,688	2,187	859	1,672
76	1,941	2,431	1,979	777	1,512	76	2,232	2,795	2,276	894	1,739
77	2,018	2,528	2,058	808	1,573	77	2,320	2,907	2,366	929	1,808
78	2,099	2,629	2,140	841	1,636	78	2,414	3,023	2,461	967	1,882
79	2,183	2,734	2,225	874	1,702	79	2,511	3,144	2,559	1,005	1,956
80	2,270	2,843	2,315	909	1,769	80	2,611	3,270	2,662	1,045	2,034
81	2,372	2,971	2,418	950	1,849	81	2,728	3,416	2,781	1,092	2,126
82	2,480	3,104	2,527	991	1,932	82	2,851	3,570	2,906	1,141	2,221
83	2,591	3,244	2,641	1,037	2,019	83	2,979	3,730	3,037	1,192	2,322
84	2,706	3,389	2,759	1,083	2,110	84	3,113	3,897	3,173	1,246	2,427
85	2,829	3,541	2,884	1,132	2,205	85	3,253	4,074	3,316	1,301	2,535
86	2,956	3,702	3,014	1,183	2,305	86	3,401	4,257	3,466	1,361	2,651
87	3,089	3,868	3,149	1,237	2,408	87	3,552	4,449	3,622	1,421	2,769
88	3,228	4,042	3,291	1,291	2,516	88	3,712	4,648	3,785	1,486	2,894
89	3,373	4,224	3,439	1,350	2,630	89	3,879	4,857	3,954	1,552	3,026
90	3,524	4,414	3,594	1,411	2,749	90	4,053	5,077	4,133	1,623	3,161
91	3,683	4,613	3,755	1,475	2,871	91	4,237	5,306	4,317	1,695	3,303
92	3,849	4,820	3,924	1,541	3,002	92	4,427	5,545	4,513	1,772	3,451
93	4,022	5,038	4,100	1,610	3,137	93	4,626	5,793	4,715	1,851	3,607
94	4,203	5,264	4,285	1,682	3,279	94	4,834	6,054	4,928	1,934	3,770
95	4,394	5,501	4,478	1,758	3,426	95	5,052	6,327	5,150	2,022	3,940
96	4,591	5,749	4,679	1,837	3,580	96	5,279	6,611	5,381	2,112	4,117
97	4,797	6,009	4,890	1,919	3,741	97	5,516	6,909	5,624	2,208	4,303
98	5,013	6,279	5,110	2,006	3,910	98	5,764	7,220	5,877	2,306	4,496
99	5,239	6,560	5,340	2,096	4,086	99	6,024	7,545	6,142	2,411	4,699

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

Effective 8-1-2024

ACE PROPERTY & CASUALTY INSURANCE COMPANY

WEST VIRGINIA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL OF STATE

	Preferred				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
65	1,372	1,605	1,400	549	1,049
66	1,372	1,605	1,400	549	1,049
67	1,372	1,605	1,400	549	1,049
68	1,372	1,649	1,400	549	1,056
69	1,379	1,698	1,406	551	1,069
70	1,397	1,749	1,424	559	1,089
71	1,440	1,802	1,467	575	1,121
72	1,489	1,864	1,518	597	1,161
73	1,542	1,930	1,571	617	1,201
74	1,595	1,998	1,626	639	1,243
75	1,658	2,078	1,691	664	1,292
76	1,725	2,160	1,759	691	1,344
77	1,794	2,246	1,829	718	1,398
78	1,866	2,337	1,903	746	1,454
79	1,940	2,431	1,978	777	1,512
80	2,018	2,527	2,058	808	1,572
81	2,109	2,640	2,150	844	1,643
82	2,204	2,759	2,246	881	1,718
83	2,302	2,883	2,347	921	1,795
84	2,406	3,012	2,453	963	1,876
85	2,515	3,149	2,563	1,006	1,960
86	2,627	3,289	2,678	1,052	2,049
87	2,745	3,438	2,800	1,099	2,141
88	2,869	3,593	2,926	1,148	2,237
89	2,998	3,754	3,056	1,200	2,338
90	3,134	3,924	3,194	1,254	2,442
91	3,275	4,100	3,337	1,310	2,552
92	3,421	4,285	3,487	1,369	2,668
93	3,576	4,478	3,645	1,431	2,788
94	3,736	4,679	3,809	1,495	2,914
95	3,904	4,890	3,981	1,563	3,045
96	4,080	5,110	4,159	1,632	3,182
97	4,264	5,340	4,348	1,706	3,325
98	4,457	5,580	4,543	1,783	3,475
99	4,656	5,831	4,746	1,864	3,632

	Standard				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
65	1,578	1,846	1,609	632	1,207
66	1,578	1,846	1,609	632	1,207
67	1,578	1,846	1,609	632	1,207
68	1,578	1,896	1,609	632	1,214
69	1,586	1,953	1,617	635	1,230
70	1,607	2,012	1,638	643	1,252
71	1,655	2,072	1,687	663	1,290
72	1,713	2,144	1,745	685	1,334
73	1,772	2,219	1,807	709	1,381
74	1,834	2,297	1,869	734	1,429
75	1,908	2,389	1,944	763	1,486
76	1,984	2,485	2,023	794	1,546
77	2,063	2,584	2,104	826	1,607
78	2,146	2,687	2,187	859	1,672
79	2,232	2,795	2,275	893	1,739
80	2,320	2,907	2,365	929	1,808
81	2,425	3,036	2,473	971	1,890
82	2,535	3,174	2,584	1,014	1,975
83	2,648	3,316	2,699	1,060	2,064
84	2,767	3,465	2,821	1,107	2,158
85	2,892	3,621	2,948	1,157	2,254
86	3,021	3,784	3,081	1,209	2,356
87	3,158	3,955	3,219	1,264	2,462
88	3,300	4,131	3,364	1,320	2,573
89	3,447	4,318	3,515	1,379	2,689
90	3,603	4,512	3,674	1,442	2,810
91	3,766	4,716	3,839	1,507	2,936
92	3,934	4,928	4,011	1,575	3,068
93	4,113	5,150	4,191	1,645	3,206
94	4,296	5,381	4,381	1,720	3,351
95	4,491	5,624	4,578	1,797	3,502
96	4,692	5,876	4,783	1,877	3,660
97	4,903	6,141	4,998	1,963	3,824
98	5,124	6,417	5,224	2,051	3,997
99	5,354	6,707	5,458	2,143	4,177

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

PREMIUM INFORMATION

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

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	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

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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.