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. 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[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

OHIO Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 436, 440-445, 450-454

	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	1,678	1,944	1,711	673	1,293	65	1,929	2,236	1,967	773	1,487
66	1,678	1,944	1,711	673	1,293	66	1,929	2,236	1,967	773	1,487
67	1,678	1,944	1,711	673	1,293	67	1,929	2,236	1,967	773	1,487
68	1,678	2,002	1,711	676	1,311	68	1,929	2,302	1,967	779	1,508
69	1,678	2,062	1,711	683	1,343	69	1,929	2,371	1,967	786	1,544
70	1,729	2,133	1,762	696	1,378	70	1,988	2,454	2,027	801	1,583
71	1,780	2,207	1,815	717	1,418	71	2,046	2,539	2,088	824	1,631
72	1,842	2,295	1,879	742	1,468	72	2,118	2,640	2,162	854	1,688
73	1,906	2,388	1,945	768	1,519	73	2,194	2,746	2,237	882	1,747
74	1,982	2,484	2,022	794	1,573	74	2,280	2,856	2,326	913	1,809
75	2,063	2,582	2,104	826	1,636	75	2,372	2,970	2,419	951	1,881
76	2,144	2,684	2,187	858	1,701	76	2,467	3,088	2,515	987	1,957
77	2,230	2,791	2,275	893	1,769	77	2,564	3,211	2,617	1,027	2,035
78	2,319	2,904	2,367	929	1,841	78	2,667	3,339	2,721	1,068	2,117
79	2,412	3,020	2,460	966	1,914	79	2,776	3,473	2,829	1,111	2,200
80	2,509	3,125	2,559	999	1,981	80	2,885	3,594	2,943	1,149	2,279
81	2,608	3,235	2,662	1,035	2,050	81	2,999	3,720	3,061	1,189	2,359
82	2,713	3,349	2,768	1,070	2,123	82	3,119	3,851	3,183	1,231	2,442
83	2,821	3,467	2,879	1,107	2,197	83	3,244	3,987	3,310	1,274	2,526
84	2,920	3,588	2,980	1,147	2,273	84	3,357	4,126	3,426	1,318	2,615
85	3,022	3,713	3,083	1,186	2,353	85	3,475	4,271	3,546	1,363	2,704
86	3,128	3,825	3,191	1,229	2,434	86	3,598	4,398	3,670	1,413	2,799
87	3,237	3,939	3,303	1,272	2,519	87	3,723	4,530	3,798	1,461	2,897
88	3,351	4,057	3,419	1,317	2,607	88	3,854	4,665	3,932	1,513	2,999
89	3,469	4,178	3,539	1,356	2,686	89	3,990	4,805	4,070	1,560	3,088
90	3,590	4,304	3,664	1,395	2,766	90	4,129	4,951	4,213	1,605	3,181
91	3,699	4,434	3,774	1,437	2,849	91	4,253	5,100	4,341	1,653	3,277
92	3,809	4,566	3,887	1,481	2,935	92	4,381	5,252	4,469	1,704	3,375
93	3,925	4,680	4,003	1,525	3,023	93	4,512	5,382	4,604	1,755	3,478
94	4,042	4,798	4,124	1,573	3,115	94	4,648	5,517	4,741	1,809	3,581
95	4,164	4,918	4,247	1,619	3,207	95	4,789	5,656	4,884	1,862	3,688
96	4,288	5,041	4,375	1,668	3,304	96	4,932	5,797	5,031	1,918	3,800
97	4,416	5,167	4,506	1,718	3,404	97	5,080	5,941	5,181	1,975	3,913
98	4,550	5,297	4,640	1,770	3,505	98	5,232	6,091	5,337	2,036	4,031
99	4,686	5,429	4,780	1,823	3,611	99	5,389	6,242	5,496	2,097	4,153

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

Household Discount Factor 0.93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

OHIO Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 436, 440-445, 450-454

	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	1,567	1,816	1,598	628	1,208	65	1,802	2,089	1,837	722	1,389
66	1,567	1,816	1,598	628	1,208	66	1,802	2,089	1,837	722	1,389
67	1,567	1,816	1,598	628	1,208	67	1,802	2,089	1,837	722	1,389
68	1,567	1,870	1,598	632	1,224	68	1,802	2,150	1,837	727	1,409
69	1,567	1,926	1,598	638	1,254	69	1,802	2,214	1,837	734	1,442
70	1,614	1,992	1,645	650	1,287	70	1,857	2,292	1,893	748	1,479
71	1,663	2,062	1,695	669	1,324	71	1,911	2,371	1,950	769	1,523
72	1,720	2,144	1,755	693	1,371	72	1,978	2,466	2,019	797	1,577
73	1,781	2,230	1,816	717	1,419	73	2,049	2,564	2,089	824	1,631
74	1,851	2,320	1,889	742	1,469	74	2,130	2,668	2,172	853	1,689
75	1,926	2,412	1,965	772	1,528	75	2,215	2,774	2,259	888	1,757
76	2,003	2,507	2,043	802	1,589	76	2,304	2,884	2,349	922	1,828
77	2,083	2,607	2,124	834	1,652	77	2,395	2,999	2,444	960	1,900
78	2,166	2,713	2,211	867	1,719	78	2,491	3,119	2,541	997	1,977
79	2,253	2,820	2,298	902	1,788	79	2,592	3,243	2,642	1,037	2,055
80	2,343	2,919	2,390	933	1,850	80	2,694	3,357	2,749	1,073	2,128
81	2,436	3,021	2,486	966	1,915	81	2,801	3,475	2,859	1,111	2,203
82	2,534	3,128	2,586	1,000	1,983	82	2,913	3,597	2,973	1,150	2,281
83	2,635	3,238	2,689	1,034	2,052	83	3,030	3,724	3,091	1,190	2,360
84	2,727	3,351	2,783	1,071	2,123	84	3,136	3,854	3,200	1,231	2,442
85	2,822	3,468	2,879	1,108	2,197	85	3,246	3,989	3,312	1,273	2,525
86	2,921	3,572	2,980	1,148	2,273	86	3,360	4,107	3,427	1,320	2,614
87	3,023	3,679	3,085	1,188	2,353	87	3,477	4,231	3,548	1,364	2,705
88	3,130	3,789	3,193	1,230	2,435	88	3,599	4,357	3,672	1,413	2,801
89	3,240	3,902	3,305	1,267	2,509	89	3,726	4,488	3,801	1,457	2,884
90	3,353	4,020	3,422	1,303	2,583	90	3,856	4,624	3,935	1,499	2,971
91	3,454	4,141	3,525	1,342	2,661	91	3,972	4,763	4,054	1,543	3,060
92	3,558	4,265	3,630	1,383	2,741	92	4,092	4,905	4,174	1,591	3,152
93	3,665	4,371	3,739	1,424	2,823	93	4,214	5,027	4,300	1,639	3,248
94	3,776	4,481	3,851	1,469	2,909	94	4,341	5,152	4,428	1,689	3,345
95	3,889	4,593	3,967	1,512	2,996	95	4,473	5,283	4,562	1,739	3,445
96	4,005	4,708	4,086	1,558	3,086	96	4,606	5,414	4,699	1,791	3,549
97	4,125	4,826	4,208	1,605	3,179	97	4,744	5,548	4,839	1,845	3,655
98	4,249	4,947	4,334	1,653	3,274	98	4,887	5,689	4,984	1,901	3,765
99	4,376	5,070	4,464	1,702	3,373	99	5,033	5,830	5,133	1,958	3,879

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

Household Discount Factor 0.93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

OHIO Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 436, 440-445, 450-454

	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	1,492	1,728	1,520	598	1,149	65	1,715	1,987	1,748	687	1,322
66	1,492	1,728	1,520	598	1,149	66	1,715	1,987	1,748	687	1,322
67	1,492	1,728	1,520	598	1,149	67	1,715	1,987	1,748	687	1,322
68	1,492	1,780	1,520	601	1,166	68	1,715	2,046	1,748	692	1,341
69	1,492	1,832	1,520	607	1,194	69	1,715	2,108	1,748	699	1,373
70	1,536	1,896	1,566	619	1,224	70	1,767	2,181	1,802	712	1,407
71	1,582	1,962	1,614	637	1,261	71	1,819	2,257	1,856	732	1,450
72	1,637	2,040	1,671	660	1,305	72	1,882	2,347	1,922	758	1,500
73	1,695	2,122	1,729	682	1,350	73	1,950	2,440	1,988	785	1,553
74	1,762	2,207	1,798	706	1,398	74	2,027	2,539	2,067	812	1,607
75	1,833	2,295	1,869	735	1,454	75	2,108	2,640	2,150	845	1,672
76	1,906	2,386	1,945	763	1,512	76	2,193	2,744	2,236	877	1,739
77	1,982	2,481	2,022	794	1,573	77	2,279	2,854	2,326	913	1,809
78	2,061	2,581	2,104	825	1,636	78	2,370	2,968	2,419	949	1,881
79	2,144	2,684	2,187	858	1,701	79	2,467	3,087	2,515	987	1,956
80	2,230	2,778	2,275	888	1,761	80	2,564	3,195	2,616	1,022	2,025
81	2,319	2,875	2,366	919	1,823	81	2,666	3,307	2,721	1,057	2,097
82	2,411	2,976	2,460	951	1,887	82	2,773	3,423	2,829	1,094	2,170
83	2,507	3,081	2,559	985	1,953	83	2,884	3,544	2,942	1,132	2,245
84	2,595	3,189	2,648	1,019	2,020	84	2,985	3,667	3,045	1,172	2,324
85	2,687	3,301	2,741	1,054	2,091	85	3,089	3,796	3,152	1,212	2,404
86	2,780	3,399	2,836	1,092	2,163	86	3,197	3,909	3,262	1,256	2,488
87	2,878	3,502	2,936	1,130	2,240	87	3,309	4,027	3,376	1,299	2,575
88	2,979	3,606	3,039	1,170	2,318	88	3,426	4,147	3,495	1,345	2,666
89	3,083	3,714	3,146	1,205	2,387	89	3,546	4,272	3,618	1,386	2,746
90	3,191	3,826	3,256	1,241	2,459	90	3,670	4,400	3,745	1,426	2,828
91	3,288	3,941	3,354	1,278	2,532	91	3,780	4,532	3,858	1,469	2,912
92	3,386	4,059	3,455	1,317	2,609	92	3,895	4,668	3,973	1,514	3,000
93	3,488	4,160	3,558	1,356	2,687	93	4,011	4,784	4,092	1,560	3,091
94	3,593	4,265	3,665	1,398	2,768	94	4,131	4,904	4,215	1,607	3,184
95	3,701	4,371	3,775	1,439	2,851	95	4,256	5,028	4,342	1,655	3,279
96	3,812	4,481	3,888	1,482	2,937	96	4,384	5,153	4,472	1,705	3,378
97	3,926	4,593	4,005	1,528	3,025	97	4,515	5,281	4,605	1,756	3,479
98	4,044	4,708	4,125	1,574	3,116	98	4,651	5,414	4,744	1,810	3,584
99	4,165	4,826	4,249	1,620	3,210	99	4,790	5,549	4,885	1,863	3,691

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

Household Discount Factor 0.93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

OHIO Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 436, 440-445, 450-454

	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	1,393	1,614	1,420	558	1,073	65	1,602	1,856	1,633	642	1,234
66	1,393	1,614	1,420	558	1,073	66	1,602	1,856	1,633	642	1,234
67	1,393	1,614	1,420	558	1,073	67	1,602	1,856	1,633	642	1,234
68	1,393	1,662	1,420	562	1,089	68	1,602	1,911	1,633	646	1,252
69	1,393	1,711	1,420	567	1,115	69	1,602	1,968	1,633	653	1,282
70	1,435	1,771	1,463	578	1,143	70	1,650	2,037	1,683	665	1,314
71	1,477	1,833	1,507	595	1,178	71	1,699	2,108	1,734	684	1,354
72	1,529	1,906	1,560	616	1,219	72	1,758	2,192	1,795	708	1,401
73	1,583	1,982	1,615	637	1,261	73	1,821	2,279	1,857	733	1,450
74	1,646	2,062	1,679	659	1,305	74	1,893	2,371	1,931	758	1,501
75	1,712	2,144	1,746	686	1,358	75	1,969	2,466	2,008	789	1,561
76	1,781	2,229	1,816	713	1,412	76	2,048	2,563	2,088	820	1,625
77	1,851	2,317	1,889	742	1,469	77	2,129	2,665	2,172	853	1,689
78	1,925	2,411	1,965	771	1,528	78	2,214	2,772	2,259	886	1,757
79	2,003	2,507	2,043	802	1,589	79	2,304	2,883	2,349	922	1,827
80	2,083	2,595	2,124	830	1,645	80	2,395	2,984	2,443	954	1,891
81	2,166	2,686	2,209	858	1,702	81	2,490	3,088	2,541	987	1,958
82	2,252	2,780	2,298	888	1,762	82	2,590	3,197	2,642	1,022	2,027
83	2,342	2,877	2,390	920	1,824	83	2,693	3,310	2,748	1,057	2,097
84	2,424	2,978	2,473	952	1,887	84	2,788	3,425	2,844	1,094	2,171
85	2,509	3,083	2,560	984	1,953	85	2,885	3,545	2,944	1,132	2,245
86	2,597	3,175	2,649	1,020	2,020	86	2,986	3,651	3,047	1,173	2,324
87	2,688	3,270	2,742	1,055	2,092	87	3,091	3,761	3,153	1,213	2,405
88	2,782	3,368	2,838	1,093	2,165	88	3,200	3,873	3,264	1,257	2,490
89	2,880	3,469	2,938	1,125	2,229	89	3,312	3,990	3,379	1,294	2,564
90	2,981	3,573	3,041	1,159	2,296	90	3,427	4,110	3,498	1,332	2,641
91	3,070	3,681	3,133	1,193	2,365	91	3,531	4,233	3,603	1,372	2,720
92	3,163	3,791	3,227	1,230	2,436	92	3,637	4,360	3,711	1,414	2,802
93	3,258	3,885	3,323	1,267	2,510	93	3,746	4,468	3,822	1,457	2,887
94	3,356	3,983	3,423	1,305	2,585	94	3,859	4,580	3,936	1,501	2,973
95	3,457	4,083	3,526	1,344	2,663	95	3,975	4,696	4,055	1,546	3,062
96	3,560	4,185	3,631	1,384	2,743	96	4,094	4,812	4,176	1,592	3,155
97	3,667	4,289	3,740	1,427	2,826	97	4,217	4,932	4,301	1,640	3,249
98	3,777	4,397	3,852	1,470	2,910	98	4,344	5,057	4,430	1,690	3,347
99	3,890	4,507	3,968	1,513	2,998	99	4,474	5,183	4,563	1,740	3,447

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

Household Discount Factor 0.93

PREMIUM INFORMATION

We, ACE Property & Casualty Insurance Company can only raise your premium if we raise the premium for all policies like yours in this State. Premiums are based on your attained age and will change on your policy anniversary date.

PREFERRED AND STANDARD PREMIUMS

Preferred and Standard premiums are shown on the premium charts. You are eligible for Preferred premiums if:

1. You apply for your Medicare Supplement insurance policy during the 6-month open enrollment period that begins on your Part B date
2. You apply for your Medicare Supplement insurance policy during your eligible guaranteed issue period, or
3. Your answer is “no” to the question on the application that asks, “Have you used tobacco in any form, including cigarettes, vapes, nicotine gum or patches, chewing tobacco, pipes, or eCigarettes in the past twelve (12) months?”

HOUSEHOLD PREMIUM DISCOUNT

You are eligible for a household premium discount if, for the past year, you have resided with one other Medicare-eligible adult who owns or who will be issued a Medicare Supplement policy from us. If you live with another adult who is your legal spouse, we will waive the one-year requirement. We may request additional documentation to determine eligibility.

Your policy's household premium discount will be terminated if the other Medicare Supplement policyholder chooses to terminate their Medicare Supplement policy or they no longer reside with you.

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.

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.

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.