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

Policy Fee $25

GEORGIA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 300-303, 311, 399

	Preferred				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
0-64	18,499	22,102	19,026	7,347	13,952
65	1,850	2,210	1,903	735	1,395
66	1,850	2,210	1,903	735	1,395
67	1,850	2,210	1,903	735	1,395
68	1,850	2,210	1,903	735	1,438
69	1,890	2,257	1,944	749	1,467
70	1,929	2,308	1,986	765	1,503
71	1,973	2,357	2,029	781	1,532
72	2,024	2,418	2,081	802	1,571
73	2,077	2,482	2,136	823	1,613
74	2,132	2,547	2,193	846	1,655
75	2,187	2,613	2,249	866	1,698
76	2,245	2,679	2,309	889	1,742
77	2,312	2,763	2,379	916	1,796
78	2,384	2,848	2,452	945	1,852
79	2,457	2,933	2,527	974	1,907
80	2,531	3,025	2,604	1,005	1,967
81	2,608	3,118	2,684	1,033	2,025
82	2,688	3,210	2,766	1,066	2,087
83	2,782	3,324	2,861	1,103	2,161
84	2,879	3,440	2,963	1,142	2,236
85	2,981	3,563	3,067	1,181	2,316
86	3,083	3,689	3,173	1,223	2,398
87	3,193	3,816	3,286	1,267	2,481
88	3,307	3,950	3,401	1,310	2,569
89	3,420	4,089	3,519	1,356	2,661
90	3,540	4,231	3,644	1,403	2,754
91	3,664	4,381	3,771	1,453	2,851
92	3,791	4,533	3,901	1,505	2,950
93	3,925	4,691	4,038	1,556	3,051
94	4,060	4,854	4,177	1,610	3,160
95	4,202	5,025	4,323	1,666	3,268
96	4,348	5,201	4,472	1,723	3,382
97	4,504	5,386	4,634	1,784	3,504
98	4,684	5,602	4,819	1,857	3,643
99	4,873	5,825	5,012	1,932	3,790

	Standard				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
0-64	21,264	25,429	21,878	8,432	16,051
65	2,126	2,543	2,188	843	1,605
66	2,126	2,543	2,188	843	1,605
67	2,126	2,543	2,188	843	1,605
68	2,126	2,543	2,188	843	1,652
69	2,173	2,596	2,236	861	1,689
70	2,219	2,653	2,285	880	1,725
71	2,267	2,710	2,332	899	1,762
72	2,327	2,780	2,395	923	1,808
73	2,387	2,854	2,458	946	1,856
74	2,451	2,929	2,523	972	1,902
75	2,513	3,005	2,586	997	1,952
76	2,582	3,081	2,656	1,023	2,003
77	2,657	3,178	2,735	1,054	2,065
78	2,741	3,276	2,820	1,086	2,129
79	2,825	3,373	2,908	1,122	2,194
80	2,911	3,477	2,995	1,153	2,263
81	2,999	3,586	3,086	1,189	2,329
82	3,090	3,691	3,180	1,227	2,401
83	3,200	3,821	3,290	1,268	2,484
84	3,310	3,958	3,406	1,313	2,572
85	3,428	4,096	3,526	1,359	2,664
86	3,546	4,240	3,650	1,406	2,757
87	3,671	4,389	3,778	1,455	2,854
88	3,801	4,542	3,910	1,506	2,954
89	3,932	4,702	4,046	1,559	3,060
90	4,071	4,865	4,190	1,613	3,167
91	4,213	5,039	4,336	1,671	3,276
92	4,360	5,212	4,486	1,729	3,393
93	4,512	5,393	4,643	1,789	3,510
94	4,670	5,583	4,804	1,850	3,634
95	4,833	5,780	4,972	1,916	3,757
96	4,999	5,982	5,142	1,983	3,890
97	5,180	6,196	5,329	2,053	4,029
98	5,385	6,443	5,541	2,135	4,190
99	5,603	6,699	5,764	2,222	4,359

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY

GEORGIA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 300-303, 311, 399

	Preferred						Standard					
Issue Age	Plan A	Plan F	Plan G	HD Plan G	Plan N	Issue Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
0-64	16,738	19,997	17,214	6,648	12,623	0-64	19,239	23,008	19,795	7,629	14,522
65	1,674	2,000	1,721	665	1,262	65	1,924	2,301	1,979	763	1,452
66	1,674	2,000	1,721	665	1,262	66	1,924	2,301	1,979	763	1,452
67	1,674	2,000	1,721	665	1,262	67	1,924	2,301	1,979	763	1,452
68	1,674	2,000	1,721	665	1,301	68	1,924	2,301	1,979	763	1,495
69	1,710	2,042	1,759	678	1,327	69	1,966	2,349	2,023	779	1,528
70	1,746	2,088	1,797	693	1,359	70	2,008	2,401	2,067	796	1,561
71	1,785	2,132	1,835	706	1,386	71	2,051	2,452	2,110	813	1,594
72	1,831	2,188	1,883	726	1,421	72	2,106	2,515	2,167	835	1,636
73	1,879	2,245	1,933	745	1,460	73	2,160	2,582	2,224	856	1,680
74	1,929	2,304	1,984	765	1,497	74	2,218	2,650	2,283	879	1,721
75	1,978	2,364	2,035	783	1,537	75	2,274	2,719	2,339	902	1,766
76	2,032	2,424	2,089	805	1,576	76	2,336	2,788	2,403	925	1,812
77	2,091	2,500	2,152	829	1,625	77	2,404	2,876	2,475	954	1,868
78	2,157	2,577	2,219	855	1,675	78	2,480	2,964	2,551	983	1,926
79	2,223	2,654	2,286	881	1,725	79	2,556	3,052	2,631	1,015	1,985
80	2,290	2,737	2,356	909	1,780	80	2,634	3,146	2,709	1,044	2,048
81	2,360	2,821	2,428	935	1,832	81	2,713	3,244	2,793	1,076	2,107
82	2,432	2,904	2,502	965	1,889	82	2,796	3,340	2,877	1,110	2,172
83	2,517	3,007	2,589	998	1,955	83	2,895	3,457	2,976	1,147	2,247
84	2,605	3,113	2,681	1,033	2,023	84	2,995	3,581	3,082	1,188	2,327
85	2,697	3,223	2,775	1,068	2,096	85	3,102	3,706	3,190	1,229	2,410
86	2,790	3,338	2,871	1,107	2,169	86	3,208	3,836	3,302	1,272	2,495
87	2,889	3,453	2,973	1,146	2,245	87	3,321	3,971	3,418	1,317	2,582
88	2,992	3,573	3,077	1,185	2,324	88	3,439	4,109	3,538	1,363	2,673
89	3,094	3,699	3,184	1,227	2,407	89	3,557	4,254	3,661	1,411	2,769
90	3,203	3,828	3,297	1,270	2,492	90	3,684	4,402	3,791	1,460	2,865
91	3,315	3,964	3,412	1,315	2,579	91	3,812	4,559	3,923	1,512	2,964
92	3,430	4,102	3,529	1,362	2,669	92	3,945	4,716	4,059	1,564	3,070
93	3,551	4,244	3,653	1,407	2,760	93	4,083	4,880	4,200	1,619	3,176
94	3,674	4,392	3,779	1,457	2,859	94	4,225	5,051	4,347	1,674	3,288
95	3,802	4,546	3,911	1,508	2,957	95	4,373	5,230	4,498	1,734	3,400
96	3,934	4,706	4,046	1,559	3,060	96	4,523	5,412	4,652	1,794	3,519
97	4,075	4,873	4,193	1,614	3,170	97	4,686	5,606	4,822	1,858	3,645
98	4,238	5,069	4,360	1,681	3,296	98	4,872	5,830	5,013	1,931	3,791
99	4,409	5,270	4,535	1,748	3,429	99	5,069	6,061	5,215	2,010	3,944

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

GEORGIA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 300-303, 311, 399

	Preferred				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
0-64	16,444	19,652	16,920	6,522	12,395
65	1,644	1,965	1,692	652	1,240
66	1,644	1,965	1,692	652	1,240
67	1,644	1,965	1,692	652	1,240
68	1,644	1,965	1,692	652	1,277
69	1,680	2,007	1,729	666	1,304
70	1,715	2,050	1,765	680	1,335
71	1,753	2,095	1,802	695	1,361
72	1,799	2,148	1,850	714	1,396
73	1,846	2,205	1,900	732	1,434
74	1,894	2,263	1,950	751	1,471
75	1,943	2,322	1,999	770	1,508
76	1,995	2,381	2,053	791	1,548
77	2,054	2,456	2,114	815	1,597
78	2,119	2,532	2,180	841	1,646
79	2,184	2,608	2,247	866	1,695
80	2,251	2,688	2,315	893	1,749
81	2,318	2,771	2,385	919	1,800
82	2,388	2,854	2,458	947	1,856
83	2,473	2,954	2,543	980	1,920
84	2,559	3,058	2,633	1,014	1,988
85	2,649	3,166	2,725	1,050	2,059
86	2,741	3,278	2,820	1,087	2,131
87	2,838	3,393	2,920	1,125	2,207
88	2,938	3,511	3,024	1,165	2,283
89	3,039	3,634	3,128	1,205	2,366
90	3,147	3,760	3,238	1,248	2,447
91	3,258	3,894	3,351	1,291	2,533
92	3,371	4,029	3,467	1,337	2,622
93	3,487	4,169	3,588	1,382	2,711
94	3,609	4,316	3,715	1,431	2,809
95	3,735	4,467	3,843	1,481	2,905
96	3,865	4,622	3,975	1,532	3,006
97	4,004	4,788	4,119	1,587	3,115
98	4,163	4,980	4,284	1,650	3,240
99	4,330	5,178	4,455	1,717	3,369

	Standard				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
0-64	18,908	22,595	19,466	7,489	14,258
65	1,891	2,259	1,947	749	1,426
66	1,891	2,259	1,947	749	1,426
67	1,891	2,259	1,947	749	1,426
68	1,891	2,259	1,947	749	1,468
69	1,932	2,309	1,987	765	1,501
70	1,974	2,358	2,030	782	1,534
71	2,016	2,410	2,073	798	1,566
72	2,069	2,471	2,129	820	1,607
73	2,123	2,536	2,185	841	1,650
74	2,179	2,603	2,243	863	1,691
75	2,233	2,671	2,299	886	1,735
76	2,296	2,739	2,359	908	1,780
77	2,362	2,824	2,430	938	1,836
78	2,437	2,912	2,507	965	1,893
79	2,511	2,998	2,583	997	1,949
80	2,589	3,092	2,662	1,026	2,011
81	2,666	3,187	2,744	1,057	2,070
82	2,747	3,282	2,827	1,090	2,135
83	2,844	3,397	2,924	1,126	2,209
84	2,943	3,518	3,028	1,168	2,287
85	3,047	3,642	3,135	1,208	2,368
86	3,152	3,769	3,243	1,250	2,451
87	3,264	3,901	3,358	1,294	2,538
88	3,378	4,038	3,477	1,340	2,625
89	3,496	4,178	3,597	1,386	2,720
90	3,618	4,323	3,723	1,435	2,815
91	3,746	4,478	3,854	1,485	2,913
92	3,874	4,634	3,988	1,537	3,016
93	4,010	4,794	4,126	1,590	3,119
94	4,152	4,962	4,272	1,645	3,229
95	4,296	5,138	4,420	1,703	3,340
96	4,444	5,317	4,572	1,762	3,457
97	4,604	5,508	4,737	1,826	3,582
98	4,788	5,727	4,925	1,898	3,726
99	4,981	5,954	5,124	1,975	3,874

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

GEORGIA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 300-303, 311, 399

	Preferred				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
0-64	14,878	17,780	15,308	5,901	11,215
65	1,488	1,778	1,531	590	1,121
66	1,488	1,778	1,531	590	1,121
67	1,488	1,778	1,531	590	1,121
68	1,488	1,778	1,531	590	1,156
69	1,520	1,816	1,564	603	1,180
70	1,552	1,855	1,597	616	1,208
71	1,586	1,895	1,631	628	1,231
72	1,628	1,943	1,674	646	1,263
73	1,670	1,995	1,719	663	1,298
74	1,714	2,048	1,765	680	1,331
75	1,758	2,101	1,809	697	1,365
76	1,805	2,154	1,858	716	1,401
77	1,859	2,223	1,913	737	1,445
78	1,917	2,291	1,973	761	1,490
79	1,976	2,359	2,033	783	1,533
80	2,037	2,432	2,095	808	1,582
81	2,097	2,507	2,158	831	1,628
82	2,161	2,582	2,224	857	1,680
83	2,237	2,672	2,301	887	1,737
84	2,315	2,767	2,383	918	1,799
85	2,397	2,865	2,466	950	1,863
86	2,480	2,966	2,551	984	1,928
87	2,568	3,070	2,642	1,018	1,996
88	2,658	3,177	2,736	1,054	2,066
89	2,749	3,288	2,830	1,091	2,140
90	2,847	3,402	2,930	1,129	2,214
91	2,947	3,523	3,032	1,168	2,292
92	3,050	3,645	3,137	1,210	2,372
93	3,155	3,772	3,247	1,251	2,453
94	3,265	3,905	3,361	1,294	2,542
95	3,379	4,042	3,477	1,340	2,628
96	3,497	4,182	3,597	1,386	2,720
97	3,623	4,332	3,726	1,436	2,818
98	3,766	4,506	3,876	1,493	2,931
99	3,917	4,685	4,031	1,554	3,049

	Standard				
				HD Plan	
Issue Age	Plan A	Plan F	Plan G	G	Plan N
0-64	17,107	20,443	17,612	6,776	12,901
65	1,711	2,044	1,761	678	1,290
66	1,711	2,044	1,761	678	1,290
67	1,711	2,044	1,761	678	1,290
68	1,711	2,044	1,761	678	1,328
69	1,748	2,089	1,798	693	1,358
70	1,786	2,133	1,837	707	1,388
71	1,824	2,180	1,875	722	1,417
72	1,872	2,236	1,926	742	1,454
73	1,921	2,294	1,977	761	1,493
74	1,972	2,355	2,029	781	1,530
75	2,021	2,417	2,080	801	1,570
76	2,077	2,478	2,135	822	1,610
77	2,137	2,555	2,199	848	1,661
78	2,204	2,634	2,269	873	1,713
79	2,272	2,713	2,337	902	1,764
80	2,343	2,797	2,408	928	1,819
81	2,412	2,883	2,482	956	1,873
82	2,485	2,969	2,558	986	1,931
83	2,573	3,073	2,645	1,019	1,999
84	2,662	3,183	2,739	1,056	2,069
85	2,757	3,295	2,837	1,093	2,143
86	2,852	3,410	2,934	1,131	2,217
87	2,953	3,530	3,038	1,171	2,296
88	3,056	3,654	3,146	1,212	2,375
89	3,163	3,780	3,254	1,254	2,461
90	3,274	3,911	3,369	1,299	2,547
91	3,389	4,052	3,487	1,343	2,636
92	3,505	4,193	3,608	1,390	2,728
93	3,628	4,337	3,733	1,438	2,822
94	3,756	4,490	3,865	1,489	2,922
95	3,887	4,648	3,999	1,541	3,022
96	4,021	4,810	4,136	1,594	3,127
97	4,165	4,983	4,286	1,652	3,241
98	4,332	5,182	4,456	1,717	3,371
99	4,507	5,387	4,636	1,787	3,505

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

Household Discount Factor .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 the same state where your policy was issued.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

PLAN A

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

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

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

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

PLAN A

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

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

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

PARTS A & B

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

PLAN F

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

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

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

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

PLAN F

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

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

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

(continued)

PLAN F

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN G

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

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

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

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

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

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

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

(continued)

PLAN G

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

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

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

HIGH DEDUCTIBLE PLAN G

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

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

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

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

(continued)

HIGH DEDUCTIBLE PLAN G

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

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

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

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

PLAN N

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

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

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

(continued)

PLAN N

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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